

Medicine, Healing and Performance



Edited by
Effie Gemi-Iordanou, Stephen Gordon
Robert Matthew, Ellen McInnes and Rhiannon Pettitt

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Back cover: The tools of a Ghanaian medicine man (© Bryn Trevelyan James 2010)

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Introduction

*Effie Gemi-Iordanou, Stephen Gordon, Robert Matthew,
Ellen McInnes and Rhiannon Pettitt*

From prehistory to the industrial age, from medico-magical charms to modern surgical techniques, the treatment of disease and trauma is a common part of human experience. The theme of this volume arose from a session which took place at the Theoretical Archaeology Group conference held at the University of Bristol in December 2010. The papers presented here provide a tantalising glimpse into how medicine has been conceived and performed across a wide geographical and chronological spectrum. The authors collectively highlight the methods by which disease and ill-health were assuaged in light of the differences in the practitioners' – and the sufferers' – worldview. An international range of archaeological and anthropological methodologies are used in order to evaluate various techniques for maintaining physical and metaphysical order.

Previous investigations into medico-magical practices have often focused explicitly on the written evidence (for example, the Anglo-Saxon leechbook traditions), the history of a single overarching event (e.g. the Black Death), grand narratives of medical tradition (that is, from Ancient Greece to the present day), or else formed single chapters in wider anthropological studies (Bloch and Parry 1982; Metcalf and Huntingdon 1991; Cameron 1993; Conrad 1995; Hatcher 2008). Where archaeological investigations have been conducted on disease and ill-health, they have tended to focus on osteological data and devote little attention to the social, performative, and ephemeral aspects of healing (Roberts and Manchester 1997; Arnott 2002; Roberts and Cox 2003). By contrast, the analysis of healing performances has traditionally been the remit of social anthropology (Roseman and Laderman 1996; Littlewood 2007). This is not to deny the importance of previous scholarship that combined archaeological, anthropological and written data to explore the cultural context of medicine (see, for example, Meaney 1981; Nutton 2006). However, this volume takes a more holistic approach by discussing the relationship between material culture, practice and social worldviews, and the interrelation between the physical and metaphysical aspects of medical treatment. Through the inclusion of topics as diverse as monastic hygiene and Neolithic shamanism this volume collates an extensive range of case studies that use interdisciplinary, theory-driven methodologies to enable a more nuanced understanding of the healing performance. Although these papers are presented in chronological order, this should not be taken to imply a

hierarchical progression of medical practices over time. Indeed, it is hoped that the reader will be able to explore the connections and contrasts that exist between these various areas of study regardless of the periods they occupy.

The Papers

The volume opens with an examination of prehistoric healing practices. Ffion Reynolds uses the concept of shamanism to interpret the possible function of the Neolithic earthwork complex at Hambledon Hill, Dorset. Drawing on her fieldwork experiences of indigenous Amazonian ethnomedicine, Reynolds argues that the somatic experience of shamanistic rituals can provide a framework for the elucidation of the archaeological residues at Hambledon Hill. In chapter two, Roger Forshaw presents a review of the medical traditions that were available in pre-Hippocratic Egypt. Using evidence from papyri sources, the paper provides commentary on a variety of interrelated techniques, including surgery, the use of aromatic oils, magical incantations, and the creation of amuletic devices. In what emerges as a common theme of the volume, Forshaw argues that no distinction can be made between empirico-rational and magical treatments of disease, given that the sacred and secular could not be separated in the Pre-Hippocratic Egyptian worldview. Whereas Forshaw's paper serves as an overview of Egyptian medicine, Jane Draycott instead focuses on a specific healing shrine in the Roman-era Egyptian city of Hermopolis (AD 117–118). Using a combination of papyrological and archaeological evidence, Draycott not only illustrates the processes of acculturation that occurred between the Egyptian and Greco-Roman worlds, but also demonstrates how political, social and economic factors could influence the creation and use of healing objects.

The conception of healing in the Middle Ages is the focus of the next collection of papers. Stephen Gordon discusses the relationship that existed between 'bad' death and the fear of contagion in twelfth and thirteenth-century England. He argues that some of the more effective techniques for allaying corporeal ghosts (revenants) in this period were structured by contemporary habits of disease containment. Gordon takes an interdisciplinary approach to the topic, using the revenant narratives from William of Newburgh's *Historia Rerum Anglicarum* (c. 1198) and archaeological examples of 'deviant' burial to explore how disease, ghost belief, and the maintenance of social and environmental cohesion were inextricably linked. Following this, the efficacy of ritual performance in a medieval context is considered by Hilary Powell, who explores the significance of the location of the shrine of St. Aebbe in Coldingham, Northumberland. Powell explains how the difficult negotiation of the local landscape was as important to the pilgrimage experience as the final supplication before the saint's shrine. Utilising written texts, primarily the *Miracula of St. Aebbe* (c. 1190s), Powell analyses the ways in which the social and political climate of the late twelfth-century Church influenced the form and function of St. Aebbe's cult. Joanna Bergqvist, drawing on sociological issues, investigates gender dichotomies in the Cistercian communities of medieval Sweden. The principle topics of discussion here are the ways in which societal and religious norms influenced contemporary perceptions of 'male' and 'female' bodies, and how this related

to personal grooming habits. Bergqvist concludes that gendered attitudes to the care of the body had a bearing on the types of surgical, medical and hygienic treatments that were available to the inmates of each community. Like Gordon and Powell, Bergqvist utilises documentary evidence (specifically the *Diarium* from the Birgittine double monastery of Vadstena) to structure her interpretation of the archaeological evidence.

The politics of body management in the mid-twentieth century provides the backdrop for papers by Kristen Burnett and Amanda Graham. Burnett evaluates the unpublished fieldwork data produced by female anthropologists working among the First Nation Niitsítapi (Blackfoot) tribes of Alberta and Montana in the 1930s. The impact of colonialism (a theme returned to by Botchway, below) and contemporary white Canadian anxieties about falling birth-rates are used to explain why previously published accounts of the Blackfoot tribe, produced by male anthropologists, omitted any mention of indigenous birth-control techniques from their arguments. Burnett argues that the investigation of these particular activities was outside the interest of the male scholars. Only the female anthropologists detailed information on the Niitsítapi's unwritten traditions of contraceptive practice. Burnett's reassessment has enabled these hitherto unpublished records to receive wider dissemination. Graham's account of the 1955 journey of the 'Hiroshima Maidens' from Japan to the United States of America for reconstructive surgery also alludes to the politics of body management. Graham's paper takes a psychoanalytical approach to the (attempted) reconciliation of the physical and mental traumas created by the atomic bomb. Graham explores complex issues of repression, hidden injury and guilt in this paper. She suggests that the Maidens' plight can be seen as a microcosm for Japan's struggle to recover from its wartime losses, as well as a way for the United States government to control the physical, visual and moral repercussions of atomic war.

Current debates on contemporary African medicine form the final section of this volume. The syncretism between Islamic and indigenous beliefs is investigated in Bryn Trevelyan James's paper using fieldwork he conducted in Medina, Ghana, as a frame of reference. James describes how African archaeology has neglected to engage the knowledge of contemporary *mai-magani* ('medicine-men') in the analysis of past material residues. It is argued that anthropological research into the types of medicine practiced in Medina, such as the creation of amuletic *kalo* devices, can be used to structure the interpretation of ambiguous finds from the archaeological record. West African conceptions of medicine are further explored by De-Valera Botchway, who provides a review of the cosmology of the Asante people of Ghana. He examines the differences between indigenous ethnomedical practices and the Western medical models imported during the colonial period. Botchway argues that the practice (and re-embracing) of ethnomedical traditions can be interpreted as a return to native roots, in essence a reaffirmation of national identity through the performance of a nearly-lost set of indigenous skills and knowledge. Ojo Melvin Agunbiade, in the final chapter, examines the traditions of herbal medicine among the Yoruba people of South-west Nigeria through both ethnographic fieldwork and historical sources. Melvin develops his discussion through a focus on the spiritual aspects of the healing process, which he argues is important in all the medical traditions active in Southwest Nigeria today.

Conclusion

The editors hope that the research presented in this volume, with case studies taken from a broad range of geographical and chronological contexts, will stimulate the imagination of the reader and demonstrate the importance of the interdisciplinary approach utilised here. During the original conference session (and, following the subsequent call for papers, during the editing process) a number of common themes emerged between the papers and which elicited much debate. The common theme shared by all papers was, of course, the element of the actual performance of medical practice, often before an audience, drawing upon socially embedded skills and knowledge, and utilising culturally specific material culture. What quickly became striking, however, was the inadequacy of modern Western medical practice as a framework for understanding such acts. Medical performance could not be evaluated solely on what would be viewed as effective from a modern perspective; rather it was guided by what was considered appropriate within a given cultural context. The papers of Reynolds, Forshaw, Gordon and Powell can be read as recoveries of these processes in the past, while James, Botchway and Agunbiade each sought to identify the rationale behind holistic medical performances in the present.

However, it became apparent that if medical performance could be reconstructed as a culturally-situated means of healing the body of the individual, it could also be seen as a means of healing the community as a whole, in response to social and political stresses. The patronage of medical performance in Roman Egypt in Draycott's paper is argued to have arisen from a political situation affected greatly by contemporary warfare. Through sponsoring the healing of individuals in a public act of munificence, an elite group could maintain its position of power. This process is echoed in Graham's discussion of the Hiroshima Maidens, as again in the aftermath of war, a position of political power is sustained through a very public performance of medical practice. In these contexts, medicine is utilised by one party as a means of affirming societal norms.

Medical performance could have adverse implications as well. Bergqvist's discussion of the role of gender in governing access to medical and hygienic resources demonstrates the impact of proscribed roles for the sexes in a late medieval context, highlighting the fact that medicine can serve as a means of control as much as of recovery. This proscribing of gender roles beyond the limits of medical practice may be observed in other contributor's papers; for instance, in the behaviour expected of the Hiroshima Maidens in Graham's paper; in the expected social role of Aline in Draycott's paper; and is visible in the publishing biases recorded in Burnett's paper. Medical performance could also be tied into other forms of social control. The impact of colonialism on medical practice is noted most strongly in Botchway's paper, as he argues for the revival of indigenous medical practices he believes were suppressed by the former colonial British administration of Asante lands.

Despite the threat posed by such cultural hegemonies, medical performance could also serve as an outlet for both resistance and adaptation. Gordon argues in his paper for the maintenance of beliefs and practices regarding the treatment of the dead in medieval England that did not necessarily tally with those of the contemporary political and

ecumenical elite. In a modern context, the papers of James and Agunbiade demonstrate the ability of medical practitioners to respond to new external influences by utilising cultural syncretism in the creation of new and innovative healing techniques, while maintaining a distinctly indigenous identity.

Overall, this volume highlights the importance of medicinal and healing performances in the exploration of cultural and social practices. It evokes the complex relationships expressed and constructed by people through performances and things in the maintenance of bodily health and wellbeing. Such relationships may, for instance, be based on the juxtaposition and convergence of indigenous and alien medical traditions, or on those indivisible connections that can exist between the physical (material) and metaphysical (spiritual, moral, political) worlds. The manner by which concepts of healing are created and maintained is further explored from the tenet that the performative aspect of the healing strategy is just as important for the maintenance of social and personal cohesion as the medicinal object. As mentioned above, gender roles, political contingencies, and the interrelationship between oral, written and material texts are issues that have impacted greatly on the perception and practice of medicine. This volume aims to demonstrate the diversity, complexity and importance of acts of healing within different cultural perspectives, and testifies to the potential of such themes in the broader study of identity and practice.

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1. Early Neolithic Shamans? Performance, Healing and the Power of Skulls at Hambledon Hill, Dorset

Ffion Reynolds

*I must be strong, my heart must be strong, eeeeeeeeee.
I have herbal remedies, I have remedies for you, eeeeeeeeee.
His blood is too weak, weaker than others;
My heart, my heart is here;
Now the machi shall know... I am seeing his blood, his heart, his bones, eeeeeeeeee.*

His bones, his heart, his heart...
His heart, his heart, his blood, his blood...
Chaw Dios, you who manage the earth above, Nuke Dios,
Give me strength to talk loudly,
Give me good words, good knowledge, eeeeeeeeee.

(Mapuche shaman's divination song, cited in Bacigalupo 2007, 61)

Introduction

This article will investigate how during certain times the material culture and deposition evident at Hambledon Hill, Dorset could be interpreted using a shamanic lens as the remains of acts where performance and healing drew together different combinations of people and things. These acts took place at various times and at specific moments in the development of the site, whether at an occasion when burying a person, a part of a person or an animal, celebrating or highlighting particular junctures of seasonal change or at points in the construction and decommissioning of particular parts of the monument. In this paper, I will specifically be investigating these instances after most of the areas at Hambledon Hill were built, including the main enclosure and Neolithic earthworks, around 3500 cal. BC. What I wish to demonstrate is that shamanic healing and performance could have linked both the living and the dead at certain points in the development of the site. This may have involved rites of passage (see Van Gennep 1960) which could be viewed as shamanic, especially if we consider the animistic basis of shamanic worldviews which incorporate the subjection of objects as powerful materials, such as skulls. To contextualise these arguments, I will draw on a range of anthropological examples which have informed most of my current theories concerning the concept of worldview.

Studies which try to get to grips with the worldviews or 'mind-sets' of prehistoric people have been around for a while, with various writers tackling the 'archaeology of mind' including the work of Colin Renfrew in 1982 (see also Renfrew and Zubrow 1994). Since then, there has been a surge of interest in 'worldview' and projects focusing on 'how we think they think' in both archaeology and anthropology (Renfrew 1982; Bloch 1998; Price 2001a; Lewis-Williams and Pearce 2005). 'Cognitive' archaeology has also proved a popular phrase used in the search for ancient thought patterns, and the topic has become rather mainstream in recent years (Pearson 2002). Even so, the vast majority of Neolithic scholars never mention the word 'shamanic' in their work, with many preferring to use less controversial themes to explain the material culture of the past, such as 'ritualistic' or 'structured deposition' (Richards and Thomas 1984; Thomas 1991; 1999; Pollard 2001). Nevertheless, as Neil Price (2001b, 13) rightly puts it, 'there can be few areas in archaeology so intimately bound up with these aspirations as the study of shamanism, itself definable as a view of the world'. This article follows in his footsteps and argues that shamanism is a powerful framework from which we can work towards a better understanding of prehistoric people and the worlds in which they lived.

To help in this search I believe it important to go out and actually experience first-hand the usefulness of a theoretical framework through anthropological fieldwork. In particular, I would like to mention a significant experience I had when visiting the Amazon jungle where I was first introduced to indigenous ethnomedicine – a tradition which usually relies on numerous forms of healing and altered states of consciousness, exercised by both specialists and non-specialists (Harner 1980; Wallis 2003; Bacigalupo 2007). During my fieldwork I took part in the collective ceremonial use of the psychotropic mixture *ayahuasca*, where participants, led by a shaman, are able to move between levels of consciousness and communicate and observe the other entities of the world (Weiss 1973; Wilcox 1999; 2003; Lenaerts 2006, 12). This relational, animistic worldview, punctured by gatherings or ceremonial 'events', which are all led by a shaman, is one way of approaching practices that relate to the understanding of the afterlife and the spirits of the dead. This experience later became a strong driver in my own research and was a useful experience for a Westerner such as myself, who privileged my own way of thinking over all others. It opened my eyes to alternative understandings of the world and inspired much of my work on the prehistory of Britain when I returned.

One aspect of that fieldwork which assisted in my research was the realisation that the cosmological complex of shamanism was intimately related to practices associated with the dead. This also resonates with an animistic worldview, in which the other entities of the world are considered to have interiority or consciousness similar to our own (Descola 2005; 2010), especially since they both imply the embodiment by the self of another's point of view (see Viveiros de Castro 1992; 1998 for a detailed discussion of Amerindian perspectivism). This is what becomes real during an *ayahuasca* vision. It brings people together and reveals the inner workings of the world in visual format. A communal experience such as this, with the shaman leading as the conductor or commutator of traditional practices and beliefs, has the great power of social healing.

It would seem, however, that visual prompts of performance and healing such as the ones that accompanied the ceremonial event I witnessed – music, dance, fire, smoke and altered states of consciousness – are aspects of shamanism which are all but invisible in the archaeological record for the Neolithic of southern Britain (Pearson and Shanks

2001). Nevertheless, I would argue with some confidence that at least some of these aspects contributed to the acts of ceremony that took place within the architecture of a causewayed enclosure. As other scholars have demonstrated with some success, we can reconstruct the kinds of activities that took place at these monuments, with a range of practices being emphasised including feasting, exchange, deposition, mortuary and ancestor rites (Edmonds 1993; 1999; Pollard 2008a; 2008b).

An important aspect of shamanic practice that is hardly discussed in the archaeological literature is how these performative acts and rituals link physically to everyday practices through the use of materials and architecture (Jordan 2001; 2003; Tambiah 1979; Turner 1974; 1986). One of those examples that does discuss this includes Aaron Watson's (2001, 178) contribution which argues that Neolithic passage tombs such as Maeshowe on Orkney were places for communal performances, and not just receptacles for housing the dead (see also Lewis-Williams and Pearce 2005; Reynolds in press). He argues that shamanic elements of those performances could have included: sensory deprivation in a cramped darkened space, smoke, fire, singing and drumming. In this article, I want to follow a similar argument and suggest that Neolithic relationships with materials such as human and animal bone were highly charged with these viewed as animistic materials and used in shamanic rituals, as reflected by practices of structured deposition (Richards and Thomas 1984; Thomas 1991; 1999; Pollard 2001).

This relationship between special materials, altered states of consciousness, healing and performance are elements of shamanism that are re-current across the globe. When we consider a typical shaman's toolkit, it may consist of several objects including: parts of animals and humans, plants, herbs, stones, minerals and stone or musical instruments, such as drums (Reynolds 2009; Santos-Granero 2009; Stoddart 2002; Vitebsky 1995; Wilbert 1977). The placing of special bone objects, such as a skull at the main enclosure at Hambledon Hill for example, may be seen as a powerful statement, as such objects could be viewed as subjectified, potent, animistic items used and presented to the spirits by the shaman to protect and enhance the enclosure itself (for a detailed discussion of animism see Hallowell 1960 and Bird-David 1999). Shamanic performances brought people together, provided a focal point for discussions about the afterlife and the other-worlds, and as such, were clearly linked with practices associated with the spirits of the dead. Placing powerful objects like isolated human skulls in the ground could have been used as part of important shamanic healing performance involving fire, smoke, drumming and dancing. This could have been a significant event, perhaps taking place after the completion of a newly constructed ditch, bank or palisade. These instances offer alternative ways with which we may engage with the acts of deposition at Hambledon Hill, Dorset.

Shamanism in Context

To begin, I will give a brief introduction to the concept of shamanism: its history and position in current debate. One of the most popular shamanic interpretations has been put forward by Piers Vitebsky (1995), who published a lavishly illustrated book on the subject. His take is detailed and argues for a universal innate shamanism which occurs in its various nuances across the world. Perhaps a more theoretical approach to shamanism

was published in Neil Price's (2001a) edited volume dedicated to the concept, highlighting how the subject is involved in a highly contested debate. For some, shamanism is a term which should not be used cross-culturally, and relates only to its place of origin in North-east Asia – coming from the language of the Evenks, a Tungus-speaking group from eastern Siberia (Shirokogoroff 1923; Anisimov 1963; Eliade 1964, 13–14; Bowie 2000, 175). Even so, other researchers, including myself believe that shamanism *can* be used cross-culturally as there are several parallel themes (Eliade 1964; Reichel-Dolmatoff 1975; Noll 1985; Vitebsky 1995; Saladin d'Anglure 1996; Price 2001b; Williams 2001; Harvey 2003; 2006; Reynolds 2006). A strong concurrent feature is the use of altered states of consciousness, and this for me is the most overriding feature of shamanism. It is this skill which sets the shaman apart from other people who may experience the same processes or experience altered states. These altered states may include the use of psychotropic drugs but not exclusively, as they may also involve several other techniques including drumming; singing; fasting; sensory deprivation; meditation; sexual restriction; dance; feats of endurance; intensive temperature conditions; sleep, dream or trance states; alcohol use and pilgrimages to specific locations (Williams 2001; Lewis-Williams and Pearce 2005; Reynolds in press). By any one of these techniques a shaman provides a means to 'act out' or perform particular tasks within the community. The shaman, from this perspective, may be viewed as an important mediator between worlds and can help solve problems within the community as well as individual patients who may be afflicted emotionally or physically. The shaman is however an ambiguous character, as he or she can harm as well as cure, heal or provide therapy (see Whitehead and Wright 2004, for a current summary of 'dark shamanism').

Linguistically, the word 'shaman' is taken from the word *šaman* and means 'skywalker' or 'one who is excited, moved, raised', deriving from the verbal roots of 'to dance, jump, shake, to be excited' (Eliade 1964; Guenther 1999; Bowie 2000, 181; Jilek 2005, 9). Traditionally, the shaman is described as the mediator between the human world and the world of the spirits, between the living and the dead, and between animals and human society. For many, shamans are believed to be endowed with clairvoyance and are assisted by helper spirits (Price 2001b). Consequently, these individuals are said to fill many social and religious roles (Eliade 1964, 182; Hultkrantz 1973, 25–37; Lewis 1981, 32; Carr and Case 2006). During shamanic ceremonies or performances, Eliade (1964, 13–14) argues that the shaman is able to cross profane frontiers to sacred fields of time and space and has the power to journey into the beyond and make contact with spirits. He or she also has specialised knowledge of myth and cosmological symbolism (Lewis-Williams and Pearce 2005). In all cases the shaman acts on behalf of and represents his or her community.

In this article, I will suggest that several materials and objects from the Hambledon Hill assemblage may have shaped the ways in which people conceptualised their worldviews. Skulls and bones, for instance, may have played crucial roles in the mediation between worlds, used in performances at specific junctures in the construction and re-negotiation of the monument. In the next section I will introduce the background to Hambledon Hill and contextualise why a shamanic approach may add to our understanding of causewayed enclosures, before I go on to give specific examples of how this action and performance may have taken place.



Figures 1.1 and 1.2. A project at Hambledon Hill in 2007, created by UK-based environmental arts group Red Earth, sought to reanimate our conceptions of performance, and incorporate much of the ethos behind Lewis-Williams and Pearce's book *Inside the Neolithic Mind* (2005). That volume – heavily influenced by a shamanic paradigm – was used as inspiration for the work and so encapsulates the types of things one would expect to find in a shamanic performance. Atsushi Takenouchi at Hambledon Hill, performing 'Enclosure' (after Staelens 2009, figs 1–3)

Hambledon Hill, Dorset: Setting the Scene

Hambledon Hill is located in north-east Dorset, and forms part of the north-west scarp of the Wessex chalk, set between the river Stour to the west and its tributary the Iwerne to the east, both of them cutting the hill off from the chalk continuum to either side (Mercer and Healy 2008, 1; Figure 1.3). It was excavated extensively by Roger Mercer between 1974 and 1986, revealing a huge and diverse amount of cultural remains including two causewayed enclosures, earthworks, two long barrows and several outworks. The chronological model suggests that earlier Neolithic activity began on the hill in 3690–3640 *cal.* BC and ended in 3340–3300 *cal.* BC. This period of use lasted for about 300–400 years (Healy 2004; Bayliss *et al.* 2008, 409).

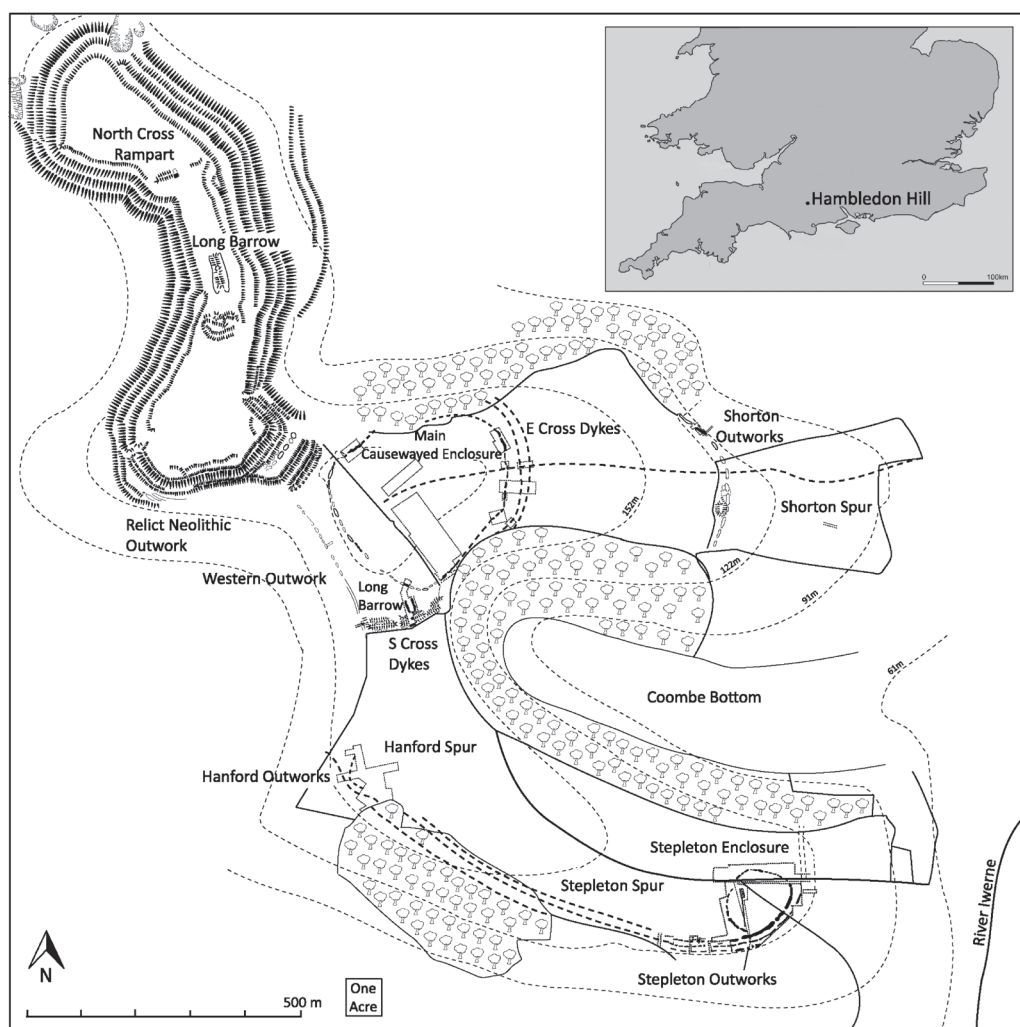


Figure 1.3. Hambledon Hill (redrawn by author, after Mercer and Healy 2008, 5, fig. 1.4)

Causewayed enclosures have been interpreted in various ways by various people through time and there is a large corpus of work available on the possible functions and detail of their construction. A thorough examination was given by Mark Edmonds in 1993. His article moves from earlier discussions (*e.g.* Piggott 1954) of economy and enclosures as central trading points (Mercer 1981), to later arguments which propose that their very location – at the edge of contemporary settlement – meant they were rarely occupied permanently and used intermittently as cattle kraals or sites for seasonal festivals (Edmonds 1993, 104, 106). Mercer's (1980) background in the military may account for his suggestion that enclosures were defensive in nature. There are only a few examples of attack known, one famous example being the 400 arrowheads excavated at Crickley Hill, all located near or around the perimeter of the site, particularly close to the gaps between the causewayed enclosure ditches (Smith and Brickley 2009, 104). This does suggest organised conflict involving large groups of people, although these attacks do not completely explain why causewayed enclosures like Crickley Hill or Hambledon Hill were built in the first place. Perhaps it is better to consider causewayed enclosures as multi-purpose sites, used both as functional arenas during the routines of daily life, as places for settlement and residence, feasting and exchange; and as places for special events such as initiation, rites of passage and the burying of the dead (Bradley 2007; Edmonds 1993; Harris 2009; 2010; Whittle *et al.* 1999).

One paper that discusses the treatment of human remains at Hambledon Hill in depth is Healy's (2004) summary, which gives detailed information and offers an excellent account of the variation in treatment. Fowler (2010) also goes some way in describing the different ways bodies were treated at Hambledon Hill, totalling in the region of some thirty-five children and forty adults remains (Healy 2004, 23; McKinley 2008, 490), which signify a range of mortuary practices. An interesting example described is the two male skeletons in the ditch of the adjacent Stepleton enclosure at Hambledon Hill. Possibly killed in conflict they were originally thought to have been shot in the back and given no funerary treatment whatsoever; however, McKinley (2008, 513) argues that one was given a covering of chalk rubble, while the other exhibits some cut marks indicating defleshing to the right tibia. Although they may have been killed some funerary attention was still seemingly given to their corpses. Perhaps these were routine practices in order to cover the body, appease the spirits and remove recognisable features. These premature and violent deaths may have been out of the norm, unexpected and dangerous.

Other, more significant burials may have required more organisation and spectacle. Some members of the community may have been especially potent, their remains needing special treatment. This may apply to witches and other anti-social persons, but it might also apply to shamans or, in a hierarchy, to the bodies of high-ranking lineages (Fowler 2010). Different bodies meant different things, but when their bones were being buried they were at the centre of the performance: celebrated and drawn from the community and valued for their own personal histories. Skulls especially may have been drawn upon to celebrate and emphasise a particular juncture in the development of Hambledon Hill, and used perhaps in a ceremony or performance that required an individual like a shaman to orchestrate the accompanying practice and burial, perhaps one that presented challenges and a need to communicate with the spirits of the dead.

The Power of Skulls

Skulls especially feature in many shamanic practices. The skull, one of the most identifiable skeletal elements in the human body, is sometimes curated after death and venerated in place of the entire person (Hill 2006, 92). In an important paper on the practice of skull modification in some societies, Hill has listed six major ways in which the human head may be perceived it can be used: to ward off spirits; as shorthand for a whole person; as an object imbued with spiritual or magical power; to aid memory; as an object to facilitate forgetting; or given as a dedicatory offering (2006, 91). A head could be obtained by decapitating an enemy, by carefully removing it from an ancestor's corpse, or by collecting it after a criminal has been beheaded. Head cults and the importance of the skull as an easily identifiable part of the human skeleton have been a common theme in archaeological interpretation. The symbolic significance ascribed may be due to the fact that the skull is seen as an easily recognisable token of the individual or the group and a clear marker of possession (Barth 1975; 1987; Hill 2006, 91; McKinley 2008, 513; Rudgley 1993; Thomas 1991).

The inclusion of whole skulls as well as skull fragments at Hambledon Hill may therefore be seen as a way of directly referencing the ancestral dead or, in a more active manner, even locating dead relatives themselves, with the skulls acting as 'containers' in which an animistic essence was deemed to reside. A similar pattern is seen in some Hindu practices in India, where the skull is split during cremation so that the spirit is released from the body (Parry 1982, 90). If the death was a bad event, the skull is broken to release the dangerous forces (Watson 1982). If the skull remains unbroken, a life-force is believed to reside within the skull, waiting to be activated by a shaman or a practitioner in acts of healing or sorcery (Parry 1982, 91). Through this, it may be argued that the skulls still carried with them strong identities and powerful essences of their own. Whether these encompassed dangerous or healing animistic qualities would depend on how the shaman was using the objects which possessed this 'life-force'. These aspects may have meant that skulls were viewed within relational networks, whose ontological status was perhaps still utterly inseparable from that of living people (Hill 2006, 92). The death of an individual, the partial dismemberment of the body and later the structural deposition of a person's skull could have been a strategy to draw on something of its raw, generative energy, helping to heal wounds and giving participants a chance to grieve, ultimately enhancing the spiritual and animistic potency of the enclosure (Halifax 1982). Taking the skull out of circulation and burying it forever would have been a powerful moment.

There is clear evidence for skulls and skull fragments across many Early Neolithic sites in southern Britain, from long barrows (Ashbee 1966; Wells 1962), to chambered tombs (Benson and Whittle 2007; Evans and Hodder 2006; Saville 1990), to flint mines (Barber *et al.* 1999; Barber 2006; Topping 1997; 2005) and causewayed enclosures (Thomas 1991, 68–69). There is also evidence for the *removal* of skulls, and this may contribute to our understanding of their significance and use. Skulls minus their mandibles are frequently found, perhaps suggesting that they were removed after decomposition for curation elsewhere. Once disarticulated, skulls may have been retained among the living or moved from one burial context to another (Smith 1965, 137). Skulls and

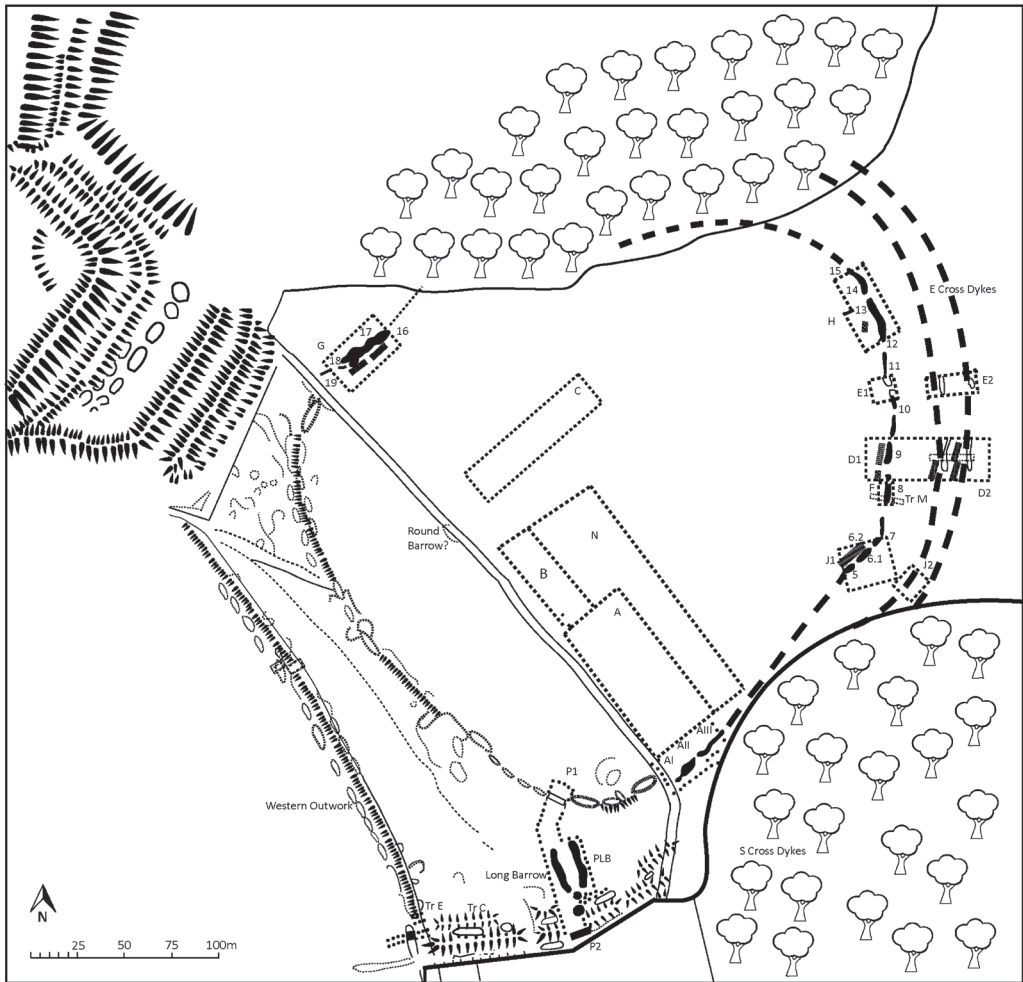


Figure 1.4. Plan of the central enclosure at Hambledon Hill (redrawn by author, after Mercer and Healy 2008, 49, fig. 3.15)

skull fragments feature in the ditches of causewayed enclosures such as at Abingdon, Whitehawk, Maiden Castle and Staines (Robertson-Mackay 1987, 46; Sharples 1991, 52; Whittle *et al.* 2011), but more importantly for this article, 13 skulls were found at Hambledon Hill, where skulls and skull fragments were placed in ditches both at the main enclosure and at the lesser Stepleton enclosure (Mercer 1980, 63; Mercer and Healy 2008, Chapter Three; McKinley 2008, 515).

At the main enclosure, built between 3680 and 3630 *cal.* BC, there are various instances of skulls and skull fragments being deposited (Figure 1.4). These included skull fragments in phase IV of segment 19; more skull fragments in phase III of segment

17; and elsewhere, the human remains were dominated by skull and limb fragments (McKinley 2008, 514–15). This material was, with rare exceptions, fragmented when deposited, as in the case of two joining skull fragments placed a short distance apart on the base of segment 3 of the main enclosure, or fragments of the same skull scattered through the slot of segment 7 (McKinley 2008, 174; Mercer and Healy 2008, 64).

It may not only have been the final resting places of these skulls and skull fragments which were important, and the above ground contexts could have held similar or equal significance. As McKinley (2008, 514) argues, most skulls and skull fragments tend to be particularly weathered and worn, with most of them subject to greater exposure to the elements than the rest of the human remains (Mercer 2008, 760). This may suggest that the skulls were curated and kept for special reasons, perhaps these people required special treatment, both during life through special activities, like body modification or ornamentation, and then after death. Shamanic individuals may have overseen the safety of those skulls, making sure that they were contained and not introduced back into the cosmos in the normal way. Some skulls may have therefore been curated before finally being deposited at the bottom of a newly constructed ditch or bank. Those people may have been directly connected to the development of that place of gathering and building.

We can imagine that people cared very deeply about how skulls were treated. Isolated human heads can be viewed as potentially powerful symbols, yet their meanings may have been contextual and varied greatly between groups and individuals, depending not only on culturally constructed notions of what dismembered bodies represent but also on how and from whom the heads were taken. This is the case in several South American contexts, as Tung and Knudson (2008, 915) argue for the Wari skulls from Conchopata, Peru, where it is difficult to ascertain exactly whether the skulls were from enemies or ancestors (Seeman 1988). Testart (2008) has also demonstrated for Near Eastern contexts that skulls are frequently excavated in isolation. However, rather than considering these skulls as evidence of a cult of ancestors, Testart argues that the skulls were trophy heads taken from enemies. Whatever the case, it is clear that skulls were used at special events and occasions as Hambledon Hill was constructed as several complete human skulls were structurally deposited at the bottom of certain ditches at the main enclosure.

One example where there is clear evidence for isolated skulls being buried comes from a context at Hambledon Hill where a row of skulls were deposited during phase II of segment 3 in the main enclosure (Mercer and Healy 2008, 64). Harris (2009) has examined this deposit and argues that it is the importance of emotion and memory which shaped the need for traditions of practice such as this. I would like to suggest that a worldview approach could bring the evidence alive even further. How were the skulls placed in the ground, who orchestrated such a spectacle? This row of skulls must have been powerful symbols of mortality, symbols of life and death, placed in isolation at the bottom of a newly formed ditch – a visual symbol of change. The remains in segment 3 (from south-west to north-east) included fragments of a young juvenile cranium which was positioned next to a joining facial area of the same skull; a mature adult female skull and a young subadult skull, possibly female, all without mandibles (Mercer and Healy 2008, 64; Figure 1.5).

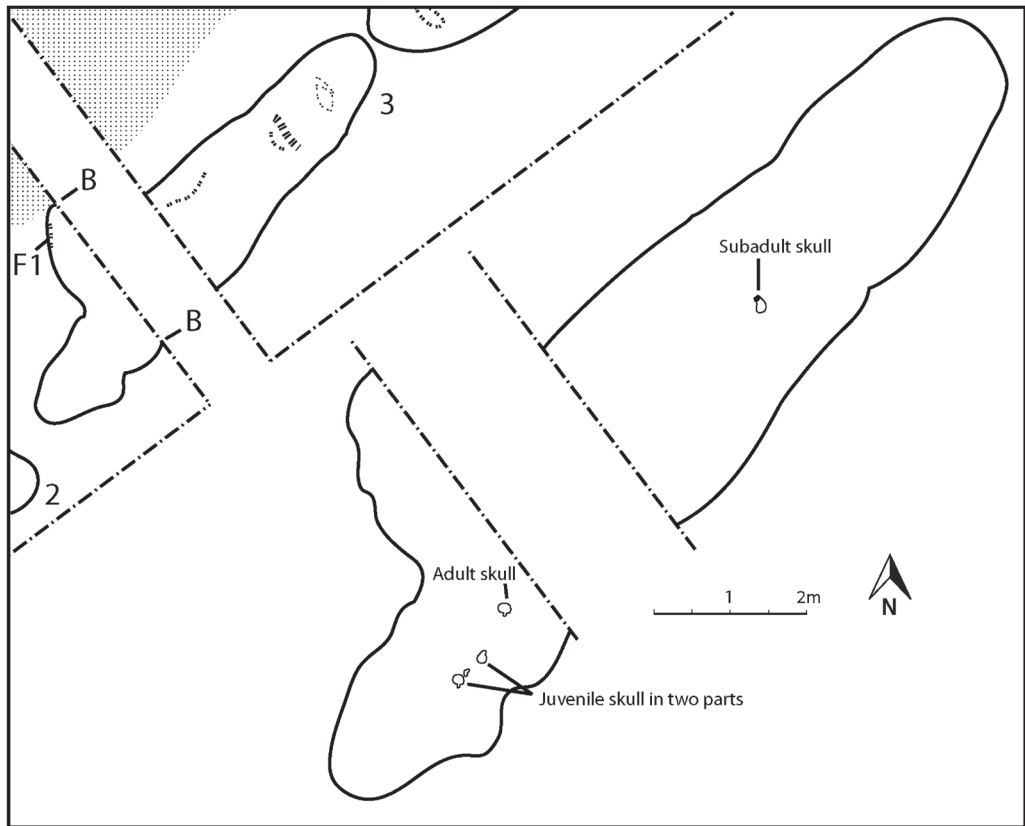


Figure 1.5. Three skulls forming a row in segment 3 of the main enclosure at Hambledon Hill (redrawn by author, after Mercer and Healy 2008, 64, figs 3.9, 3.11 and 3.12)

Harris (2009) points out that there are a number of instances in which non-adjacent fragments from different phases were found to match, for example HH74 HB 5 (mandible) and 6 (skull minus mandible) from different phases within adjoining segments of the main causewayed enclosure ditch (McKinley 2008, 515). This skull forms part of the deposit in phase II of ditch segment 3, with the mandible belonging to it from phase III of segment 4 (Mercer and Healy 2008, 64). When McKinley's interpretation is taken into account here (2008, 515) – that up to 80% of the skulls were curated for longer periods of time than other bones – it may be suggested that the mandible and skull belong to the same earlier date, perhaps around the beginning of the development of the site, were kept and then later deposited. What we can argue is that the movement of the skull mandibles connects the deposits in phase III of segment 4 directly with the certainly earlier ones of phase II in segment 3 (Bayliss *et al.* 2008, 384). The later placing of the mandible in phase III of segment 4 drew on previous performances and ceremonies when the skull was originally placed, and was perhaps used to re-enforce the power of the spirit evoked

– added later to complete a particular rite of passage or communication with the spirits of the dead (HH74 HB 5; fitting skull HH74 HB 6 from Phase II deposits in segment 3). Perhaps the skull was kept as a special object by an individual similar to a shaman, called upon, used, curated or even displayed before reaching its final resting place, with the mandible kept for an even longer period of time before being deposited. Harris agrees (2009) that it is difficult to give an exact time period between the placing of the skull and the later placing of the mandible, but it has been suggested that a reasonable approximation could be about 30 years (Bayliss *et al.* 2008, 384).

These issues are reminiscent of the acts of use, display and curation evident among the Mountain Ok of Inner New Guinea, studied extensively by Fredrik Barth (1987). There bones are curated in string bags containing fingerbones, clavicles, breastbones and mandibles while skulls, skull fragments and long bones are displayed in the central *Yolam* or ‘ancestor-house’ (Barth 1987, 3). It is interesting to note here that skulls and other bones are separated out into two different categories. A skull may be kept on display, while other bones are carried around in string bags. In the case of a skull, Barth (1987) recalls that for at least twenty years during his fieldwork, only one complete example served as the focal point for direct manipulation and handling, displayed against the inner wall of the ‘ancestor-house’ between two sacred fires. The skull itself was known to be of a particular group; however, it was used to represent the category of *all* ancestors. Shamanic acts were always directed towards this particular skull for all different ritual purposes, and it was even painted white, red, or both according to the nature of the occasion. The skull itself did not necessarily have to be a direct relative of the shaman conducting acts of performance, or otherwise the other participants and audience, its main purpose being a common direction for shamanic dialogues with the dead (Barth 1987, 3; Vitebsky 1993).

These analogies, used tentatively, may cast light on the ways in which the skull and mandible at Hambledon Hill were utilised in particular performances. The skull itself may have been curated, displayed, perhaps actively engaged with through the practice of its painting when in circulation and in use by the living – its powerful presence used to evoke the dead or to drive away malevolent entities through acts of healing. The skull could have then been buried as part of a ceremony to celebrate the construction of a major ditch; placed at the bottom of this ditch it would have formed a powerful visual moment as it sat in isolation. The mandible was kept as a physical reminder of the deposited skull, a portable object that could be called upon to represent the skull and used as a power object in itself.

Conclusion

The manipulation of the human body after death, as I have suggested throughout this article, was a crucial aspect of a Neolithic worldview. There were various ways of doing this, and this article has touched upon how this played out at the main enclosure at Hambledon Hill, Dorset. Similar depositional patterns have been noted at other causewayed enclosures, such as Windmill Hill (Whittle *et al.* 1999), Etton (Pollard 2008a; Pryor 1998), and Briar Hill (Bamford 1985). The sites at Carn Brea, Helman Tor,

Hembury, Maiden Castle and Hambledon Hill, as well as other less major interspersed sites not mentioned here (but see Mercer 2003), are linked by a common distributional pattern of artefacts and raw materials being circulated over very considerable distances. Materials were moving in all directions – bone, pottery, flint, other quarried stone – and these materials passed beyond Hambledon Hill further into Wessex. These sites could also benefit from a re-working which takes worldview, such as shamanism and animism seriously.

Through the archaeological examination of shamanism and by using anthropological analogy we get closer to the intangibles that are so important a part of our research but yet so difficult to get at. One way I approached that distance was to go out and experience shamanism firsthand in South America, where I became party to alternative worldview systems that offered a philosophical position which permitted me to move beyond notions of subject and object, and nature and culture. This in particular has important consequences for an archaeologist like myself, since I am Western, and our way of thinking primarily deals with material we deem to be inanimate, inactive, ‘dead’ material culture – including pottery, stones and bones. We consider these materials from a buried, distant past, and then actively employ our own epistemological and scientific reasoning onto this past, drawing distinctions between nature and culture; human and non-human.

Alternative indigenous epistemological reasoning such as shamanism or animism can present entirely different conceptions of materials or landscapes and what it is to be human, have personhood, a body and agency. These worldviews contrast radically with those of modern archaeologists whose rationalist, humanist, and largely materialist approaches are heavily influenced by eighteenth-century enlightenment thought. By studying and employing alternative worldviews such as shamanism to our archaeologies, however, we may be able to understand better why people in the Neolithic placed the deposition of human bone at the centre of a variety of ceremonies which reworked interconnections between material, person and place (Thomas 2002; Wallis 2009, 48). As with the deposits of skulls at the main enclosure, these drew upon the acts of deposition set within an architecture that focused people’s attention on to a stage where theatre and ritual took place led by a suitable individual like a shaman, citing and transforming people’s understandings of the world.

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2. Before Hippocrates: Healing Practices in Ancient Egypt

Roger Forshaw

Introduction

Evolving from a collection of competing Predynastic regions at the end of the fourth millennium BC, Egypt unified into a single state. This marked the beginning of over 3,000 years of Pharaonic civilisation in the Nile Valley, a period that saw many social, political and cultural changes. Sophisticated though it was by the standards of its time, life in ancient Egypt would have presented many hazards. The population lived in close proximity to dangerous animals such as crocodiles and hippopotami which inhabited the river Nile and its banks. Snakes and scorpions encroached into the arable land upon which the population lived. Diseases borne by insects and parasites were a continual threat and manual workers in the many quarries and construction projects would have risked life and limb on a daily basis (Allen 2005, 9). The average life expectancy for the ancient Egyptian was short, perhaps only about thirty-five years (Filer 1995, 22–25; Nunn 1996, 22). Consequently, it is no surprise to find in the archaeological and textual record many references to health, disease, and the diverse agencies which cause disease processes. Healing and health issues would have been a significant concern for everyone throughout the Pharaonic age (3100–30 BC), a time period that provides a rich source of material and written evidence for the practice of healing and is the subject matter of this study.

A variety of approaches and treatment strategies to cope with infirmities were undertaken in ancient Egypt and these have been the subject of an extensive literature (Grapow *et al.* 1954–1973; Jonckheere 1958; Ghalioungui 1963, 1980, 1983, 1987; Majno 1975; Worth Estes 1993; Bardinet 1995; Filer 1995; Weeks 1995; Nunn 1996; Ebeid 1999; Halioua and Ziskind 2005). A number of previous discussions on healing practices have attempted to distinguish between empirico-rational therapies and magico-religious actions, rather than considering both methodologies as complementary to one another. In ancient Egypt empirical knowledge and magical actions were equally valid parts of the complex cultural system, and the healer seems unlikely to have actively distinguished between them when treating a sick member of the community (Weeks 1995, 1787; Ritner 2001a, 326).

One key problem in attempting to examine the role of healers and healing is the extent and quality of the evidence available and the manner in which this evidence has

been interpreted. Analysing the past in terms of modern concepts can be misleading, and interpretations need to be based as much as possible on understandings likely to be prevalent in an ancient society at that time. Consequently, to explore the concepts of healing in ancient Egypt it is first necessary to examine beliefs about the causation of illness as well as their perception of healing.

Etiology of Disease and Concepts of Healing

Similar to other ancient societies, the Egyptians interpreted the experienced world according to patterns of knowledge different from those of the modern Western world. Supernatural powers were regarded as major controlling influences in the course of daily life. These not only included phenomena such as changing weather patterns and the annual flooding of the river Nile, but also the causation of disease. Illness could be instigated by a variety of agents such as malevolent spirits or powers which included not only the deities, but also living and dead persons as well as animals. In the case of a traumatic injury, such as a wound or bite, the agent was the actual perpetrator of the injury, but for a disease the agent was personified as a so-called 'disease-demon' (as termed by Nunn 1996, 96). These demons travelled on the breeze and entered the victim through external orifices such as the mouth, nose or a break in the skin (Walker 1990, 85–86).

The primary source of information concerning these demons is to be found in magical formulae recorded on papyri and ostraca of the Middle Kingdom (c. 2055–1650 BC) and later periods (Translated: Borghouts 1978 and Leitz 1999, and discussed by Sweeney 2006; Kousoulis 2007; Szpakowska 2009; Lucarelli 2010). Examples of these magical incantations can be found in the medical papyri (referred to later) such as the verso of P. Edwin Smith 1 (11–16. Translated: Allen 2005, 107; c. 1550 BC): *'Another (incantation) for barring air of the bitterness of the night-demons, those of smallness, Sekhmet's messengers'*. The heart was considered to constitute the mind as the ancient Egyptians recognised the heart as the centre of emotions, memory and intelligence. Thus in P. Ebers 855u (102.4–5. Translated: Ghalioungui 1987, 227; c. 1534 BC): *'As to vanishing of the heart and forgetfulness: it is the breath of the (harmful) doing of the lector that does it. It enters the lung several times and the heart becomes confused through it'*.

Because of the manner in which disease processes were understood, treatments for ailments were aimed at expelling these agents, and, typically for Egyptian culture, healing practices were allied to religious practices and ritual action. Egyptian religion drew heavily upon myths and the influence of these mythic narratives is evident in the magical incantations, ritual processes and the medicaments used in healing (Walker 1993, 100).

Chief among narratives of the gods involved in healing is that of Osiris, the god believed to have once ruled Egypt in the mythic past. He was murdered by his brother Seth, who dismembered his body. Osiris's wife-sister, Isis, herself a powerful magician and healer, collected the scattered body parts and through her actions with the dead Osiris was able to conceive a son, Horus (Quirke 1992, 57–69; Assmann 2005, 23–26). Isis nursed Horus, protecting and curing him through her magical abilities. Because of

her mythical role, Isis became a popular deity to be invoked for protection and cure. There were various other myths that ancient Egyptian practices drew upon when an individual was suffering from an illness. In cases where there was a related myth, he or she could identify him/herself with the victim of the myth and appeal for divine curative help (Walker 1993, 95). Such appeals and prayers are attested throughout the Pharaonic Period and private prayer to the deities would have formed an important component in the healing system.

Certain gods were particularly identified with healers and healing. Re, for example, was considered to have devised many magical incantations and Thoth, the god identified with writing and knowledge, wrote these remedies down and passed them onto mankind:

'He (Re) said: I am the one who will protect him (the patient) against his enemies. His guide is Thoth; he causes books to speak; he composed compilations of writing (remedies); he imparts useful knowledge to the learned, to the physicians his followers...'

(P. Ebers 1, 1–11. Translated: Ghalioungui 1987, 9)

Gods were also associated with many of the medicaments that were used in the treatment of ailments, these compounds being drawn from a wide range of animal, mineral and vegetable products. P. Salt 825 (II.5; Ptolemaic Period, c. 332–330 BC) links a number of compounds with Re, such as honey which was considered to come from the 'tears of Re' (Derchain 1965, 137). P. Ebers 242–47 lists a number of ointments to be applied to the head and which are asserted to have been prepared by Re himself (Ghalioungui 1987, 81–83).

However, the efficacy of a particular medicament was interpreted by the ancient Egyptians as a magical power inherent in that substance, rather than the material having a recognisable chemical or physical property. The substances were deemed effective by their ability to drive out the disease demon or other agent from the body and so heal the individual.

Many of these substances still remain unrecognised and one problem in their identification is that the Egyptians named these products according to different criteria than are in use today. Appearance was important, for example, dill (*imst*) was called 'hairs of a baboon' and chickpea (*Hr-bik*) 'falcon-face', due to the superficial resemblance of the plants to these animals (Germer 1998, 85). Coding or alternative naming of the materials is recorded in a late Greco-Roman papyrus (P. Leiden I 12.408–44). In the text 'crocodile dung' is a synonym for 'Ethiopian clay' and 'a man's bile' is 'turnip sap'. The text contains a translation key together with explanatory notes in an attempt, it was claimed, to prevent untrained laymen from preparing medicaments deemed to be the sole domain of the priests. Although the papyrus dates to the Greco-Roman Period (332 BC–AD 394), the introduction states that the interpretations are copied from earlier works compiled by temple priests and translated from ancient Egyptian (Dielman 2005, 185–87).

As with many aspects of healing practices, geographical and temporal factors need to be considered as it is quite possible that the names of some of the substances would not have remained the same throughout 3000 years of Pharaonic history. Germer (1998, 86) uses the example of the yellow dye fustic to illustrate this point. Fustic is obtained from

the wig-tree (*Cotinus coggygria*) which is native to Europe and Asia. However, when the New World was settled, Europeans transferred the name fustic to the yellowwood tree (*Chlorophora tinctoria*), resulting in fustic now being obtainable from a different plant.

Sources of Information

The exceptionally dry climate and unique burial customs of the ancient Egyptians have resulted in the survival of well-preserved skeletal and mummified remains, a valuable resource able to provide primary information regarding health, disease and healing. However, care has to be taken with the interpretation of this material. Samples of the surviving human remains are never statistically representative of Egyptian society, as many of them belong to one group or class, such as elite individuals or those buried together in workers' cemeteries. Mummification and desiccation can adversely affect the remains, changing the composition of material and potentially affecting the results of modern analytical techniques (for a description of the scientific study of mummies see David 2008).

One area where skeletal and mummified remains can supply useful information is in determining to what extent the ancient Egyptians utilised surgical techniques for the treatment of disease and trauma. The textual and archaeological records are only able to supply indirect evidence. An example of such being metal artefacts which are believed to be medical surgical tools, but as most of these have not been found in known physicians' tombs nor are they inscribed with their function, their intended purpose is uncertain. There is a depiction of what are believed to be surgical instruments on a wall of the temple at Kom Ombo which dates to the Greco-Roman Period, but again it is possible that they were meant to serve a non-medical purpose (Forshaw 2009, 484). It is difficult to identify surgical procedures for certain in the medical papyri. There are ten references to 'knife treatment' (*Dwa*) in P. Ebers, and a relief in the tomb of Ankhmahor, a high ranking official during the Sixth Dynasty (c. 2345–2181 BC) has been interpreted as depicting circumcision.

However, excavations at Deir el-Barsha of remains dating to the Second Millennium BC (Dupras *et al.* 2010, 405–23), and from Thebes of remains dating from the Second and First Millennium BC (Nerlich *et al.* 2010, 117–21) have revealed a few cases that display palaeopathological indicators of amputation, surgical removal of bone fragments and evidence of healing. Amputations displaying successful healing patterns are recognised amongst the skeletal remains of the Old Kingdom (c. 2686–2125 BC) pyramid builders at Giza. Here there is also evidence of simple and compound fractures of the long bones of the skeleton. Many of these fractures demonstrate effective healing and good alignment, an outcome which could only be achieved by the correct use of splints (Hussein 2010, 85–89). Objects identified as splints have been recovered from a 5th Dynasty (c. 2494–2345 BC) tomb at Naga ed-Deir and well-healed fractures, again requiring the use of splints, have been reported amongst the approximately 6000 skeletal and mummified remains (dated from c. 4000 BC–AD 1000) which were unearthed during the First Archaeological Survey of Nubia (1907–1911; Nunn 1996, 176). However, other than amputations there is no firm evidence for advanced surgical procedures from the

human remains during any period of ancient Egyptian civilization (Nunn 1996, 165).

Examinations of teeth and their supporting structures have helped to determine whether an operative dental profession existed in ancient Egypt. A dental review of the evidence for the whole Pharaonic Period examining bridges, the possibility of extractions and the suggestion that 'holes' were drilled into the bone surrounding teeth to drain abscesses does not support earlier claims for the existence of dental surgery. Management of dental conditions seems on the whole to have been restricted to the application of medicaments listed in the medical papyri (Hoffman-Anthelm 1979, 77; Leek 1967, 58; Miller 2008, 31; Forshaw 2010, 72–77).

This skeletal evidence can be supplemented by examining surviving artistic depictions such as wall paintings, reliefs and sculptures. However, these artistic sources have to be viewed with caution as the representations of the human body and disease processes displayed on them were subject to the conventions of Egyptian art, and may not accurately represent real-life conditions. A particular statue or painting was not intended to be an accurate portrait, but rather an ideal image of an individual to be remembered for eternity, irrespective of age, appearance or infirmity (Assmann 1996, 55–81).

It is from textual sources that we find the most detailed evidence of healing practices, with the medical papyri being the most important of these. There are in addition numerous ostraca that record individual remedies dating from the New Kingdom (1550–1069 BC) to the Greco-Roman period. There are approximately fourteen texts which can be regarded as medical papyri with the earliest of these, P. Kahun (UC 32057), dating to about 1820 BC and the latest, P. Vienna 6257, believed to have been written in the Second Century AD (Ritner 2000, 108). No medical papyri date to the Old Kingdom and so information about healing practices during this period is restricted to other sources, but as Weeks (1995, 1793) notes, some of the papyri display 'frequent usage of archaic orthography, grammar and vocabulary', suggestive of them being copies of older works. However, this is typical of texts claiming antiquity and thus authority. It is therefore uncertain if they are reproduced from earlier compositions. There is evidence that ancient Egyptian healing practices were influenced by foreign cultural exchanges as the London Medical Papyrus (P. BM. 10059, c. 1350 BC) contains seven incantations transcribed from Semitic and Cretan languages (Ritner 2000, 110).

The content and usefulness of the papyri varies considerably and there is a degree of duplication amongst them. Translational difficulties with the identification of a number of the components of the remedies make it difficult to judge the effectiveness of some of the pharmaceutical preparations. Some papyri, such as P. Chester Beatty (c. 1200 BC) and P. Ramesseum (c. 1700 BC), have suffered extensive damage. Despite these problems, two of the better preserved papyri, P. Ebers and P. Edwin Smith, are particularly useful in understanding the ancient Egyptian approach to healing. The Ebers papyrus (c. 1534 BC) is the largest medical papyri preserved and is a collection of some 877 separate therapies. As seventeen of the remedies are repeated and six pairs are almost identical, the suggestion is that the papyrus is a compilation from more than one source (Nunn 1996, 32). The papyrus documents treatments for various diseases affecting different parts of the body, and like many of the papyri, each therapy comprises a number of different elements. These consist of medicaments, magical incantations and in some

cases explicit mention of ritual performance. The existence of these different forms of remedies has resulted, as indicated previously, with some authors arguing that in ancient Egypt there was a rational empirical system of healing practices parallel to a magico-religious system.

There are instances in the papyri of remedies involving only the mention of substances and others just incantations, but many of the treatments involve both (Walker 1990, 87). An example of such a remedy is P. Ebers 61 (18.21–19.10. Translated: Ghalioungui 1987, 24–25) which is aimed at eliminating the *HfAt*-worm from the belly:

‘Sedge 5 ro; SAms-plant; boiled in honey; eaten. Its spell: The burden is loosened; the weakness departs that one who is on his belly has put in this my belly that a god has created, that an enemy has created. What is harmful to it (to the worm); the god loosens what he has done in this, my belly.’

(The *HfAt*-worm is thought to be a parasitic worm infecting the gut, see Nunn 1996, 71–73. The *ro* is a unit of measure and the botanical identification of the *SAms*-plant is uncertain).

Even when there is no magical incantation associated with a particular remedy and it could be argued that the treatment is purely rational, there are many generic magical incantations in the papyri which would have been an expected complement to any treatment. The first three remedies of P. Ebers (Translated: Ghalioungui 1987, 9–12) are examples of just such non-specific incantations. P. Ebers 1 (1.11): *‘The beginning of an utterance to apply a remedy to any part of the body’*; 2 (1.12–2.1): *‘Another utterance to loosen anybody’s bandage’*; 3 (2.1–6): *‘Utterance to drink a remedy’*. These three remedies then detail the incantation, and the implication is that their use is available for all subsequent therapies involving the application of a medicament, the removal of a bandage, or the oral taking of a medicine.

Consequently, the lack of incantations associated with some of the treatments does not suggest an exclusively rational approach, but rather incantations were omitted from the text and a general invocation recited (Ritner 2001a, 327). Pharmaceutical remedies and magical incantations were part of a single consistent method of healing and both integrated parts were administered by the same practitioner. This system would also involve the use of incantations during the preparation of compounds, with each major ingredient being potentiated by a separate invocation (Walker 1990, 87).

Many of the remedies in the papyri list several alternatives for managing a particular ailment with no one treatment recommended in preference to another. It would appear that the ancient Egyptian practitioner was not compelled to choose one particular mode of therapy over another; choice would seemingly depend on experience and personal preference. An example of this approach is provided by three alternative remedies to treat the common cold that are listed in P. Ebers. The first of these recommends drinking date juice, which would have a soothing affect and is recognised today as having health benefits (Ebers 761, 90.14. Translated: Ghalioungui 1987, 193–94). The second remedy advocates the use of plant material which is *‘rubbed with dates’* and introduced into the nose (Ebers 762, 90.14–15). The type of plant recommended is uncertain but is suggestive of a ‘snuff-like’ material. The third lists a medicament as well as a magical incantation directed at the cold, and in this particular remedy the cold is recognised as a ‘disease demon’ (Ebers 763, 90.15–91.1). The cold is exhorted to flow out of the

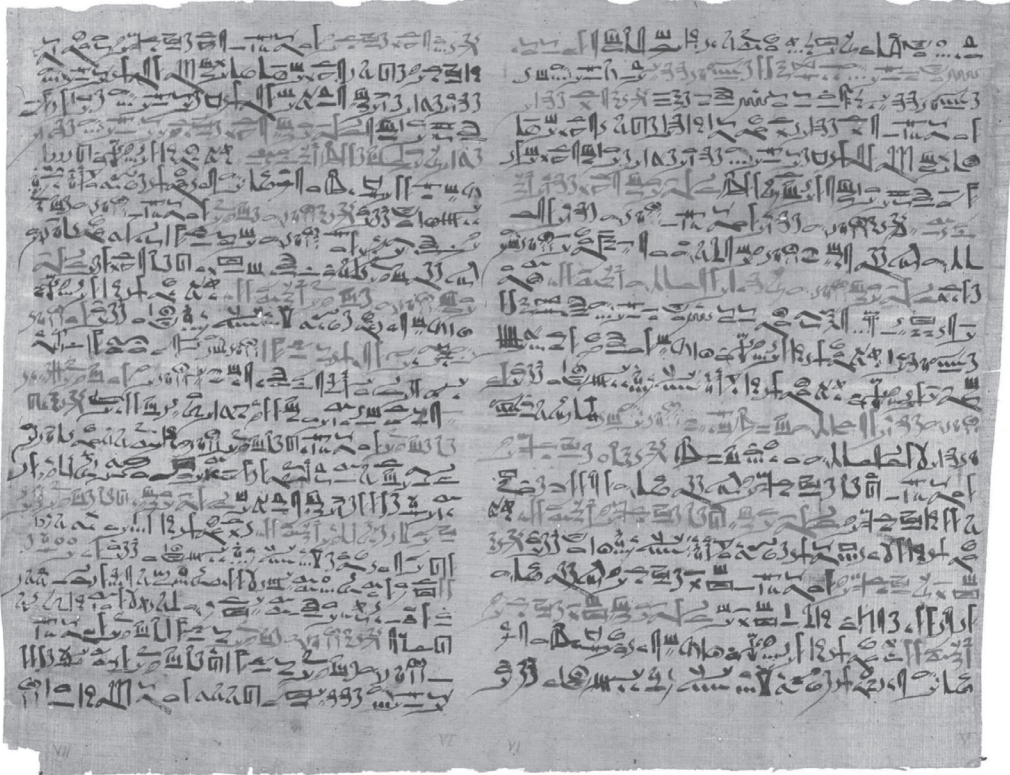


Figure 2.1. Verso of the Edwin Smith papyrus, written in hieratic. Dated c. 1600 BC (New York Academy of Medicine)

inflicted individual by means of a recitation over the milk of a woman, who has borne a male child, while at the same time a fragrant gum is to be inserted into the nose. The gum could be soothing for a sore nose, whilst the use of milk is symbolic of milk from the goddess Isis who used her milk to cure her infant son, Horus (Ritner 2001a, 328).

Milk from a mother who had borne a male child is frequently mentioned in the medical papyri as a curative agent and was considered useful in treating a number of ills, both for children and adults. This use of a mother's milk is similarly documented in other cultures (see Dioscorides, 5.99; Pliny, 28.21), and was also later recognised by the Egyptian Copts and the Arabs (Chassinat 1921, 301). Other bodily fluids such as urine and blood were used as treatments for particular bodily ailments, either as a convenient vehicle for constituents of the remedy or because of their divine associations (Ebers 537, 808 in Ghalioungui 1987, 145 and 205; Worth Estes 1993, 104; Tyldesley 2010, 203).

Another important papyrus which provides details of healing practices is P. Edwin Smith (c. 1550 BC). This text is a sophisticated example of medical literature, being the earliest known treatise dealing with surgery (Fig. 2.1). The papyrus lists forty-eight cases, commencing at the head and systematically progressing to the thorax. The

absence of any examples below this level implies a missing section to the papyrus. The cases mainly relate to trauma with instructions on how to treat open wounds to the skull, broken noses, fractures and dislocations. More severe injuries are described but the advice listed in the papyrus is to avoid treatment in these cases. Due to the nature of the injuries listed, the papyrus was probably intended to be used by a healer who had to deal with major trauma such as battlefield and construction site injuries (Weeks 1995, 1795; Nunn 1996, 29–30).

Case 25 of the Edwin Smith Papyrus provides advice for correcting a dislocated mandible. It shows a clear logical approach differing little from the method that is practiced today and is the earliest description of a surgical procedure still in use (Lipton 1982, 112). Moreover, P. Edwin Smith contains the first recorded use of absorbent lint made from vegetable fibre whilst splints and bandages are routinely used. It describes the use of adhesive strips in dealing with wounds, and cases of complex suturing are described in detail. It is clear from this papyrus that minor surgery was known, understood and practiced in ancient Egypt and that some of this knowledge is still in use today (Forshaw 2009, 485).

The Healing Practitioners

The practice of healing was not carried out by a single class of individuals but rather a number of different types of healers were involved in treating illness. The ‘physician’ (*swnw*), the ‘magician’ (*sAw*), together with various categories of priests such as the ‘lector’ (*Xry-Hbt*), the ‘pure priest’ (*wab*), the ‘priest of Sekhmet’ (*wab sxmt*), and the ‘controller of Serket’ (*xrp srqt*) all had some involvement in healing practices. There is also evidence in the New Kingdom and later for ‘local healing’ such as workmen at Deir el-Medina being practised in healing techniques, and ‘wise women’ (*rxwt*) who were skilful in detecting and combatting spirit possession (Borghouts 1982, 25; Pestman 1982, 155–72). The complementary nature of healing practices involving magical incantations, performative ritual and the use of medicaments is well illustrated in some of the working practices of the different healers. The ‘controllers of Serket’, who treated snake bites and scorpion stings, examined snakes by description, toxicity and considered the reptile’s divine associations. As a consequence they made use of incisions, topical applications and invocations to divinities in their healing practices (Sauneron 1989, 180–88; Ritner 2001a, 326). The association of the lector with writing and recitation in temple and funerary ceremonies made him a ritual expert and accorded him an association with healing. In P. Berlin 3038 (10, 10–11. Translated: Wreszinski 1909, 19; c. 332 BC–AD 395), the lector is named as prescribing and applying a healing balm: ‘Another ointment to dress a wound: Pork grease, to be coated by an excellent lector, who knows this ointment’ Also in P. Chester Beatty 15 (5–8. Translated: Bordinet 1995, 478; c. 1295–1069 BC): ‘Remedy for the driving out of illness from the mouth ... relating to the activities of the lector. Acacia leaves, leaves of the Arou tree, panther skin...’

Techniques Utilised in Healing Practices

The element of magic present in the remedies would have been an important factor in healing practices, since the suggestion and expectation of a cure is acknowledged as having a positive effect on a patient, a phenomenon recognised as the placebo effect (Vernon 1994, 69–70). The placebo effect would be enhanced by factors such as the rituals performed, the pronouncement of an incantation and the professionalism of the practitioner.

The competence of a healer to correctly diagnose an ailment and select an appropriate medicament is undoubtedly an important factor in the treatment process. But also of relevance is the reputation of the healer and the image he projected. The ability of the healer to engender an atmosphere of authority and confidence would have a positive effect on a patient, but a lack of these qualities may well result in the patient become sceptical and unresponsive to suggested stimuli. Attention may be focused on the speech of the healer both in its content and presentation. There may be an element of hypnosis at play in a susceptible patient and the performative aspect of the ritual would increase the desired effect (Győry 2002, 279).

Ritual actions may well have been an integral part of the healing procedure but these are not always described in the medical papyri. Many treatments merely list the incantation and the constituents of the remedy, possibly because any such actions were considered routine. Perhaps the practitioner possessed other papyri in addition to the medical papyri or he may have been trained in the oral tradition of magic. Moreover, it has to be recognised that the surviving medical papyri are only a very small percentage of the textual material on this subject that once existed in ancient Egypt.

One action frequently referred to in the medical papyri involves the use of hands by the practitioner. In case 4 of P. Edwin Smith (2.2–11. Translated: Allen 2005, 74) the hands of the practitioner are used as a diagnostic aid: *'If you treat a man for a gaping wound in his head ... you have to probe his wound. Should you find something there uneven under your fingers...'* Again in case 17 (1–7. Translated: Allen 2005, 85): *'If you treat a man for a fracture in his cheek, you have to put your hand on his cheek in the area of that fracture'*. Although all these and other cases suggest that hands are being used in a diagnostic capacity, the practice could also refer to the rite of 'Laying on of hands' (Majno 1976, 105; Nunn 1996, 115). This ritual action is common to many religions, it is practised by lay healers and in addition to it being a healing gesture it can also symbolise the conferring of blessings and the appointment of leadership. Moreover, it is a popular gesture seen throughout history, and physical contact is reassuring which in itself is beneficial.

Another important element in healing practices in ancient Egypt was the use of water which was associated with both ritual purification and healing, the two acts often being closely related. In temple rituals, water was poured on statues or offered to the deities as a drink in symbolic recognition of the rejuvenating power of the Nile (Poo 2010). From the New Kingdom onwards healing statues and stelae are attested. The latter being known as Horus cippi after the image of the god, shown triumphing over snakes and dangerous animals. A large part of the cippus was inscribed with magical incantations which were not expected to be recited, as the power of the stela was obtained by pouring



Figure. 2.2. Limestone stela of Qenherkhepeshef from Deir el-Medina. Dated c. 1200 BC (Courtesy of the British Museum, EA 278 ©The Trustees of the British Museum)

water over the stone and then drinking or applying the charged fluid (Ritner 1993, 106–07; Kákosy, 1999; Allen 2005, 63–64).

The use of water as a healing medium is attested on the 19th Dynasty (1295–1069 BC) stela of Qenherkhepeshef (BM EA 278) where there is a reference to sleeping in the temple court and drinking sacred water (Quirke 1992, 136; Fig. 2.2). This practice was to further develop in the Ptolemaic Period when temples such as that at Dendera practiced immersion in sacred water, reflecting the influence of Greek culture and particularly the Greek god, Asclepius (Wilkinson 2000, 74–75). The sacred water from the temple symbolised a ritual cleansing medium aimed at averting illness, giving thanks for continued good health, or seeking a cure for diseases and disabilities. In this same period incubation or temple sleep is attested, in which it was hoped that the deity of the temple would visit the sufferer in a dream either healing directly or recommending a cure (David 2007, 116).

Alongside the use of water as a purification and healing medium, incense and aromatic oils can be recognised in the

same context. Incense is first explicitly attested in a ritual context in Utterance 269 (376) of the Pyramid Texts inscribed on the walls of the Old Kingdom pyramids, but here the composition of the incense is unknown (Faulkner 1969, 77). By the New Kingdom substances such as myrrh and frankincense were known to have been imported and burned for their fragrant incense (Manniche 1999, 36–53). By the end of the Pharaonic civilisation, kyphi (a mixture of resins, herbs and spices) was increasingly being used. Kyphi was also recognised for its medicinal properties being taken as a draught to cleanse the body, whilst the scent of kyphi was considered soothing and inductive to sleep (Griffiths 1970, 80). A number of aromatic oils mentioned in P. Ebers were considered beneficial as healing remedies, such as juniper oil (*wan*) to treat tapeworm (*pnd*) (85, 23.1–2); acacia oil (*Sndt*) used in the treatment of wounds (527, 70.24–71.1), and cumin oil (*tpnn*) to treat headache (770, 92.5–6) (Translated: Ghalioungui 1987, 29, 143, 197).

Together with the spoken word, ritual action and use of a medicament, healing practices would also have involved the use of ancillary objects. The most widespread of these was the amulet, an object which, because of its shape, colour or the material from which it is fashioned, was believed to magically endow the wearer with certain powers

and capabilities (Andrews 1994, 6; Pinch 2006, 104–19). By uttering a magical incantation over an appropriate object, the item would be potentiated, thus providing it with a magical power which would then be available to ward off hostile forces. The amulet maker or seller (*sAtw*) is listed in both P. Ebers (854a) and P. Edwin Smith (1, gloss A) alongside the physician and the priest of Sekhmet as one of the three professionals who could determine the pulse rate, thus being closely associated with medical diagnosis. Even at this early stage in history the value of monitoring the pulse was recognised as part of a patient examination.

A poorly preserved section (B.20–23) in P. Ramesseum 3 (EA 10756. Translated: Bardinet 1995, 470; c. 1780–1680 BC) seems to refer to the use of an amulet: *‘To drive out the baa (a noxious substance?): to say as an incantation ... acacia. Turn it (the amulet?) to the left and put around the neck of a child’*. In P. Ebers 811 (95.7–14. Translated: Ghalioungui 1987, 206), a remedy for a disorder of the breast, there is mention of various plants and grasses twisted into a twine, knotted and placed on the afflicted site, again an example of an amulet. Knot amulets were also used preventatively as they were considered a barrier through which hostile forces could not pass, with the colour, material and number of knots relevant to its particular function (Pinch 2006, 84; Wendrich 2006, 244). Spells were written down on pieces of linen or papyrus and then rolled up and worn around the neck as protective amulets. Additionally, they could be ingested or attached to the affected part of the body with contact between the written word and the afflicted individual. It was believed that the actual inscription would aid in healing without the need for an oral rendering of the invocation (Ritner 2001a, 328; Pinch 2006, 70).

There are a few examples of so-called ‘wands’ fashioned from bronze and shaped to resemble a serpent, but more widespread are depictions of individuals holding serpents with the rationale for such imagery being identifiable in spell 885 of the Coffin Texts (Faulkner 1973, 49; Fig. 2.3). This indicates that by grasping the serpent or any dangerous animal, the creature is rendered harmless and the power of the creature can then be directed against hostile forces (Ritner 2006, 213).

In the Middle Kingdom ivory wands inscribed with images of apotropaic figures including dangerous animals, demons and serpents are attested (Fig. 2.4). Their purpose seems to have been one of conferring protection by directing the power of fierce deities against evil forces,



Figure. 2.3. Bronze serpent staff from a Theban burial. Dated c. 1550–1500 BC (Courtesy of the British Museum, EA 52831 ©The Trustees of the British Museum)



Figure. 2.4. Hippopotamus ivory wand showing incised representations of deities and 'fantastic animals'. Found at Thebes. Dated c. 1900–1700 BC (Courtesy of the British Museum, EA 18175 © The Trustees of the British Museum)

and they appear to safeguard the most vulnerable in society such as pregnant women, nursing women and children (Altenmüller 1983, 35). It seems reasonable to assume that these objects were used in some contexts by healers and perhaps also by the less initiated. Other classes of ritual object used for healing may exist in the archaeological and textual record, but have as yet evaded identification as healing accoutrements.

Transference was another technique utilised in healing practices, with the damaging effects of a poison or a disease demon able to be transferred either to a medication, an animal or to an object. In Ebers 356 (57.17–21. Translated: Ghalioungui 1987, 107), a cure for blindness, the humour of a pig's eye was poured into the ear of the afflicted person whilst reciting: '*I have brought this and placed it in the place of that (the disease eye) and substituted the terrible suffering*'. If an inanimate object was used, then after the ritual the object was often smashed or broken to dispose of the damaging agent (Ghalioungui 1963, 35; Pinch 2006, 80).

Wound licking is an instinctive response by many animals and humans to an injury. Within most cultures there is the belief that saliva has curative properties. Today it is recognised that saliva contains many useful compounds that are antibacterial and promote healing, with histatins (small proteins with antimicrobial and antifungal properties) recently been identified as a major wound-closure factor (Oudhoff *et al.* 2008, 3805). In ancient Egypt the ritualised use of spitting and licking is documented in several of the textual sources on myth and healing (Ritner 1993, 73–110).

In the Heliopolitan creation myth (Coffin Text 76) spittle from the sun god Atum produced new life in the form of the gods Shu and Tefnut (Faulkner 1973, 77). Both the Pyramid and the Coffin Texts describe the licking of written spells and drawn images in

order to ingest their efficacy. In texts of purification rituals, saliva serves as a medium to convey invigorating power, and its curative nature is emphasised in funerary literature (Ritner 1993, 78–79). There are a number of references to spitting in the medical papyri, such as spitting out of the venom from a snake bite and another treatment aimed at improving restricted breathing following a snake bite which is described as *'opening the throat'*. Here difficulty in breathing would be due to the venom from the snake blocking nerve impulses into muscles, eventually resulting in paralysis. The remedy in the papyrus involves a mixture of onion, beer and northern salt: *'Grind, swallow, spit out for four days'* (P. Brooklyn No. 47.218.48, col 3/9. Translated: Ritner 1993, 81; Sauneron 1989, 66; c. 380–330 BC). Natron reduces swelling by osmosis and onion can reduce the sting of a bite when applied topically, but whether systemic administration of these compounds, as suggested here, would be effective is doubtful. In P. Berlin 13602 (1.6. Translated: Erichsen 1954, 368–69; c. 1295–1186 BC) there is a gynaecological remedy involving various roots: *'You spit their juice at her face with your mouth'*. The tradition of healing saliva and spitting has continued throughout the ages and even today: the Moslem holy men of North Africa transmit their blessing through the medium of saliva, and Fijian fishermen allow dogs to lick their wounds to promote rapid healing (Ritner 1993, 92; Benjamin *et al.* 1997, 1776).

Prevention

On the verso of P. Edwin Smith Papyrus (translated: Allen 2005, 107) there are a number of magical incantations aimed at preventing disease, possibly the plague (incantation 2 has already been mentioned on page 26). Incantation 1 (1, 1–10) states: *'Incantation for barring the air of a disease year...and finishes with ...'It is the year's protection; it is a bitterness repeller in a year of disease'*. Similarly, incantation 3 (1, 17–19): *'Another protection for a disease year'*. There are insecticides listed in the medical papyri such as P. Ebers 840 (97.15–16. Translated: Ghalioungui 1987, 213): *'Beginning of the recipes that one prepares to eliminate fleas in the house: you must sprinkle with natron water so that (they) get away'*. There were also remedies to ward off snakes such as P. Ebers 842 (97.17–19) and 843 (97.19) (Translated: Ghalioungui 1987, 214).

Herodotus (2.37; 77–79), writing in the 5th Century BC, highlights the ancient Egyptian concern with health and cleanliness by stating that they frequently purged themselves, took care of their diet and washed their clothes regularly. Paragraph 150 from P. Hearst (c. 1450 BC) is an antiperspirant preparation, and upper class houses in the New Kingdom had shower and toilet facilities (Weeks 1995, 1791; Brovarski 1997, 182). Ritual purity was important for priests and would have also been so for the magician or practitioner who was about to engage in a magical ritual. This purity would have involved complicated ablutions by the individual and cleansing of the area where the rite was to be performed. Purification rituals would have helped with infection control, although this was not their intended purpose. However, there is little mention of general cleanliness and washing of wounds in the medical papyri, unlike in Greek medical practice where the recommendations of Hippocrates were to wash wounds with wine or vinegar (Hippocrates VIII 420 (17), 129 (5)). Nevertheless, remedies

listed in P. Edwin Smith include the application of fresh meat to a wound; dressings consisting of honey mixed with animal fat; the use of copper salts, and adhesive linen tape, all of which have a scientific rationale.

One unusual statement found on a number of occasions in the papyri which relates to both treatment and prevention is to leave the patient '*at his mooring stakes*'. This is later clarified in the glosses at the end of the therapies as meaning bed-rest with a normal diet and with no medicaments necessary. This is a basic treatment regime still employed today in current medical practice (Majno 1975, 96; Ritner 2001b, 354).

Summary and Conclusion

Research into diseases and healing therapies in ancient Egypt involves the study of many aspects of its civilisation. The scientific investigation of mummified and skeletal remains supplemented by an analysis of textual sources and artistic representations have yielded a wealth of information on health, disease and healing practices. Many diseases that the ancient Egyptians suffered from have now been identified. Their understanding of the origin of these ailments has, however, been interpreted according to patterns different from those of the modern west.

The healing practices that were employed in ancient Egypt involved a combination of magical incantations, performative ritual and the utilisation of a wide range of medicaments. The suggestion that there was a distinction between empirico-rational therapy and the use of incantations and rites ('magic') in the treatment of disease in ancient Egypt is not valid. Such a distinction is not one the ancient Egyptians themselves would have recognised; they would not separate the sacred from the secular. Different elements of healing practices are complementary to one another rather than in conflict.

Although in the modern world the power of magic is often dismissed as being an antiquated belief, many of the healing rites and ceremonies described in the medical papyri would probably have had a beneficial psychological effect on the patient. The curative value of suggestion and expectation of cure that magical ritual would have achieved may well have been an important factor in the practice of healing in ancient Egypt.

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3. Who is Performing What, and for Whom? The Dedication, Construction and Maintenance of a Healing Shrine in Roman Egypt

Jane Draycott

Introduction

In *Theatre/Archaeology* Mike Pearson and Michael Shanks state that ‘theatre archaeology begins with a simple premise: that the description and documentation of devised performance – that matrix of places, objects and activities, of performer and context, worker and workspace, agency and structure – constitute a sort of archaeology, a rescue archaeology of the event’ (Pearson and Shanks 2001, 57). In this paper, I aim to undertake this sort of rescue archaeology and access a series of performances that took place in the vicinity of the Egyptian city of Hermopolis early in the reign of the emperor Hadrian. I do this using *Papyrus Giessen 20* (hereafter *P. Giss. 20*) a documentary papyrus that contains a letter written by a woman named Aline to her husband Apollonios, who was the *strategos* of the district of Apollonopolites Heptanomia in Middle Egypt, in around AD 117–118. I will examine who was performing, what they were performing, and for whom they were performing. Through Aline’s discussion of her communication with the saviour gods, the Dioskouroi, her subsequent dedication and construction of a healing shrine in their honour, and her attempts to make arrangements for the shrine to be maintained by a manufacturer of votive artificial limbs, some of the social, economic and even political contexts of healing practice amongst the Greek communities of Egypt during the Roman period can be revealed. Aline was performing an act not only of religious devotion, but also of patronage, euergetism, commemoration and celebration, responding to the consequences of a Jewish Revolt that had devastated the inhabitants of the Hermopolite nome by threatening their lives, damaging their land and destroying their property before it was finally put down. By incorporating literary, documentary and archaeological evidence, this paper will examine how Aline’s shrine could have provided a means of healing not only the individual but also the community.

Performance Theory and the Performance of Medical and Healing Practices

Pearson and Shanks describe performance as both ‘a mode of cultural production that works with material and intellectual resources to create meaning’, and ‘a special world

set aside from everyday life by contractual arrangements and social suspensions, not entirely hermetically sealed, but a devised world, all the elements of which – site, environment, technology, spatial organisation, form and content, rules and practices – are conceived, organised, controlled and ultimately experienced by its orders of participant’ (Pearson and Shanks 2001, 27). The Classical world of ancient Greece and Rome has been described as having a ‘performance culture’, for ‘alongside the recorded and recordable history there thrived a consistent but variable tradition of presentation: of storytelling, mockery and subversion; of dance, music and mask; of religion, secular and political expression’ (McDonald and Walton 2007, 2). Certain aspects of this tradition of presentation such as Greek and Roman plays and dramatic performances, religious rituals, ceremonies and festivals, and displays of military and political rhetoric, particularly those which occurred in Athens and Rome, have received considerable attention in recent years (Beard, North and Price 1998; Gunderson 2009; McDonald and Walton 2007). However, the place of the performance of medical and healing practices within this tradition of presentation has been neglected.

With regard to the presentation and performance of medical and healing practices in antiquity, practitioners such as physicians, surgeons, and dentists frequently not only consulted with but also treated their patients in front of an audience. This audience may have consisted of any combination of the following: the family and friends of the patient, the patient’s slaves, the practitioner’s slaves, apprentices or colleagues, or even interested onlookers. This would have depended upon whether the practitioner was working in the comparative privacy provided by a house, a surgery, or a lecture theatre, or in public in a forum, an *agora*, or a bath-house (see for example Galen’s *On the Natural Faculties* 1.13; *On the Use of the Pulse* 2.3 and 3.3; *On the Affected Parts* 3.3; *On the Therapeutic Method* 2.5) (Fagan 2002, 90–93; Mattern 2008, 14–21 and 80–90). Healing temples and sanctuaries (frequently associated with the god Asklepios, such as those at Epidauros, Cos, Pergamon, Corinth and Athens) also encouraged their devotees to act publicly, through the making of a sacrificial or votive offering, or even undertaking an incubation ritual. This dual nature of medical and healing performance (not only as something to be done but as something to be seen to be done) was emphasised by the fact that such temples and sanctuaries were frequently located next to or near theatres, and this has led to the recent suggestion that theatrical performances could have been incorporated into the therapeutic process (Hartigan 2005, 2009).

P. Giss. 20: the letter and its contents

Αλινῇ Απο[λλωνίῳ τῷ]
 ἀδελφῷ[ι ... χαίρειν.]
 εὐχαριστοῦμεν πα[σι τοῖς θεοῖς περὶ τῆς ὑγίαιας]
 σου ὅτι σε καὶ ἀπο[...]
 ἡ ἐπιστολὴ σου τὴν [...]
 που ἀπέστρεψεν [...]
 μων. ἡ δὲ προέλε[υσις ...]
 ὥστε μηδὲν θεωρεῖσθα[ι ...]
 ἀηδῶς ἔχειν διὰ τὸ διαστ[...]

γενόμενον μετὰ κισσον[... ἔγραᾶ]
 ψας περὶ τῆς ὑγίας σο[υ ... κ ...]
 νοι εἰσίν. οἰκοδομ[εῖς ...]ως[...]
 οἰκοδόμοις καὶ τέκτο[σι ...]χο[...]
 γιον. ἐργά[σο]μαι τὰ ἔρια [καθὰ] ἔγρα[ψάς μοι ὅποι-]
 ον δέ σοι χρῶ[μ]α ἀρέσκει [δήλω]σον δι' ἐπ[ισ]τολῆς
 ἢ μεικρὸν ἔρ[γο]ν αὐτοῦ π[έμ]ψον. εἰ θέλεις ἀνὰ
 βληθῆναί σου τ[ῆ]ν ἰσχνή[ν λε]υκὴν στολήν, φρόν-
 τισον τῆς πο[ρ]φύρας. ἐχρ[η]ματίσ[θ]ην ὑπὸ τῶν
 Διοσκούρων τῆς κτήσεως [σ]ου καὶ ὠκοδόμηται
 αὐτῶν ὁ τόπος καὶ Ἄρειος [ὁ] κωλοπλάστης θε-
 ραπεύει αὐτοὺς καὶ ἔλεγ[ε]ν ὅτι, ἐὰ[ν] Ἀπολλώ-
 νιός μοι γράψῃ περὶ αὐτ[ῶ]ν, [θεραπεύ]σω προῖκα.
 ἀξιῶσεις οὖν δίστιχον αὐτῶι γραφῆναι, ἵνα
 ἀξίως σου καὶ τῶν θεῶν ἀόκνως προσέλθῃ.
 τὰ παῖδιά σου ἔρρωται καὶ [ἀσπάζ]ε[τα]ί σε. σὺ
 χ<v>ὡς ἡμῖν γράφε περὶ τῆς ὑγίας σου· πάντα ᾗ
 ἔχεις Δισκᾶτος πέμψον [...]
 [...]οι[...]
 Ἀπολλωνίωι ἀδελφῶι

(Duke Databank of Documentary Papyri, 2011)

Aline to Apollonios her brother, greetings. We give thanks to all the gods because of your safety ... You wrote about your health ... You are building ... builders and carpenters ... I am working at the wool as you wrote ... tell me by letter which color [sic] pleases you or send me a small sample of it. If you want your light, white garment to fall down, give heed to the purple. I was given a response by the Dioscuri [sic] of your estate, and a shrine has been built for them. Areios the maker of votive limbs provides the service for them; he was saying, "If Apollonios writes to me about it, I will serve free of charge." You really ought to write him a couple of lines, in order for him to come forward promptly in a manner worthy of you and the gods. Your children are in good health and salute you. Write to us continuously about your health. Send what you have of Diskas ...

[Address on the verso] To Apollonios her brother (trans. Bagnall, Cribiore and Ahtaridis 2006, 152–53).

At the time Aline was writing, the city of Hermopolis Magna was the capital of the Hermopolite nome, itself one of seven nomes known collectively as the Heptanomia in Middle Egypt that had been subject to extensive Greek settlement during the Hellenistic period (Bagnall and Rathbone 2005, 162–67). Hermopolis was located on the western bank of the Nile and surrounded by an enclosure wall. A few years later in AD 130, the Roman emperor Hadrian would found the city of Antinoopolis, in memory of his lover Antinoös, directly opposite Hermopolis Magna on the eastern bank of the Nile. The northern part of the city was where the majority of the temples were located; the city's patron deity was Hermes (the equivalent Egyptian deity was Thoth) and there was a vast temple dedicated to him and enclosed by walls. There were also temples dedicated to the Greek goddesses Tyche, Athena and Aphrodite, as well as the Egyptian god Sarapis and the personification of the Nile (temples to the emperor Hadrian and

Antinoös respectively would later be built there too). The southern part was where the civic amenities were located, and these included a *komasterion*, an *agora* and a *macellum* (Alston 2002, 131–32 and 238–41).

P. Giss. 20 is part of the Apollonios Archive, a collection of over two hundred administrative and personal documents found at Hermopolis on land that was probably once part of the family's extensive estates. The archive was excavated clandestinely and its components were subsequently divided up between a number of different academic institutions and museums (Tcherikover and Fuks 1960, 226–27). Although the archive has not yet been studied in its entirety, the letters written during the Jewish Revolt of AD 115–117 have been collated as part of the *Corpus Papyrorum Judaicarum*, and in recent years those written by the women of Apollonios' family have been scrutinised for what they reveal about the lives of women in Egypt during the Roman period (Tcherikover and Fuks 1960, 225–54; Rowlandson 1998, 118–24; Cribiore 2001a, 223–39; 2002, 149–66; Bagnall *et al.* 2006, 139–63). However, in addition to the information that can be gleaned from *P. Giss. 20* with regard to Aline's level of education and literacy, the letter also contains intriguing information about healing: through the letter's discussion of the dedication, construction and maintenance of a healing shrine, it is possible to elucidate some of the social, economic and political contexts of healing practice in Egypt during the Roman period.

The beginning of the letter contains the expected greetings and *προσκυνήματα* (*proskunēmata*), standard epistolary conventions found in numerous private letters from Egypt during the Roman period. Although Aline greets Apollonios as her 'brother' (brother–sister marriage was frequently practised in Egypt during the Roman period) it is unlikely that the marriage was actually incestuous (Huebner 2007; Remijsen and Clarysse 2008; Rowlandson and Takahashi 2009). It is more probable is that Aline is using 'brother' here as a term of endearment; kinship terms such as 'brother' and 'sister', 'son' and 'daughter', 'mother' and 'father' were frequently employed by spouses and close friends in their letters to each other as signs of affection and enthusiasm (Rowlandson 1998, 119–20). Aline then refers (in a section that is unfortunately fragmented) to a mansion that Apollonios was having built elsewhere (Husson 1983, 313–19). The next subject under discussion is the weaving of wool for the production of clothing for her husband, a traditional and respectable pastime for reputable women in the Graeco-Roman world (Rowlandson 1998, 265–70). The remainder of the letter deals with something more unusual: the dedication, construction and maintenance of what appears to have been a substantial healing shrine.

A letter sent from the architect Herodes to Apollonios (part of a series of missives exchanged between the builder and the *strategos* regarding the construction of the latter's new mansion) makes reference to that building's household shrines, which (along with parts of the breakfast room) are to be carved out of wood: οὐ πάντως λανθάνει σε τὰ ἐπείγοντα ξυλικά ἔργα τῶν τε ἱερῶν καὶ τῆς ξενία[ς] (*P. Brem.* 15.3–4, 29 August AD 118, Hermopolis). It is possible to gain an idea of how these household shrines would have looked from models that have survived from antiquity, such as the one in Figure 3.1. Household shrines such as these would have contained painted portraits or statues of Egyptian, Greek and Roman deities, and miniature versions of the equipment used in religious rituals in temples such as lamps and incense burners (Frankfurter 1998, 131–42).



Figure 3.1. Terracotta model of a portable wood and wickerwork shrine, first or second century AD (image courtesy of the British Museum, inv. 1886.1006.10)

The building project that Aline has undertaken is something altogether different. Herodes refers to τὰ ἱερά (*hiera*), holy places or perhaps cult objects, while Aline uses the expression ὁ τόπος (*topos*), a geographical location. She writes that she has been in communication with the Dioskouroi of Apollonios himself; perhaps he viewed the Dioskouroi as his patron deities or, as is more likely considering the reference to ἡ κτήσις (*ktēsis*), his property, they were for some reason especially venerated in that particular area (Augé 1986, 593–97; Hermary 1986, 567–93). In any case, having received some sort of sign from them, she has undertaken the dedication and construction of a shrine; quite literally, she has built a house, οἰκοδομέω (*oikodomeō*), for them. Thus Aline's shrine would probably have been something more akin to the one depicted in Figure 3.2 (Bailey 1988, 48–49). A shrine like this would have provided a venue for local people (and perhaps even pilgrims from further afield) to pray, sacrifice and make votive offerings, thus affording

them the opportunity to enter into and sustain personal relationships with their gods (van Straten 1991, 65). Both sacrifices and votive offerings (the former intended for immediate consumption, the latter intended to endure) were often presented to redeem a vow that had been previously made through prayer, but they could also be made in advance, to ensure help or protection at an undetermined point in the future if necessary (van Straten 1991, 72).

In addition to dedicating and constructing the shrine, Aline has also taken steps to arrange for it to be maintained. To this end, she has solicited the services of Areios, a manufacturer of artificial limbs, ὁ κωλοπλάστης (*kōloplastēs*) which could have served a dual purpose as anatomical votive offerings, perhaps even resembling the ones depicted in Figure 3.3. This is as opposed to a manufacturer of terracotta figurines, ὁ κοροπλάστης (*koroplastēs*), such as the one depicted in Figure 3.4, which were deposited at all types of shrines, not just those dedicated to healing deities. The incorporation of objects such as these into religious rituals related to ancient beliefs regarding the importance of reciprocity (that if you make an offering to the gods, they will give something to you in return, or that if the gods give you something, you must make an offering to them in return) and quality (that the finer or more elaborate the offering, the more effective the prayers accompanying it will be), but also enable public demonstrations of piety, status and wealth (van Straten 1991, 63–77). It is probable that Areios utilised the silt that



Figure 3.2. Terracotta lamp modelled after a shrine, first century AD (image courtesy of the British Museum, inv. 1893.1114.1)



Figure 3.3. Terracotta anatomical votives (eye, ear, uterus, breast), third to first century BC (image courtesy of the British Museum, inv. 1839.0214.54)

was readily available in the Nile valley to make the majority of his anatomical votives (as was the case with the craftsmen of the model in Figure 3.1, the lamp in Figure 3.2, and the statuette in Figure 3.4), but it is also possible that he (or a colleague) crafted finer ones out of marble and precious metals (both available from quarries and mines in



Figure 3.4. Terracotta statuette of a young male religious devotee bearing offerings of fruit, first to second century AD (image courtesy of the British Museum, inv. 1979.0403.1)

Egypt's Eastern Desert) for individuals of high status and wealth, and the difference between these offerings would have been immediately apparent (Uhlenbrock 1990, 15–21).

The acquisition of a suitable offering (whether it was specially commissioned or simply chosen from an available selection) was a performance in itself, with the supplicant performing for both a human audience (consisting of the craftsman responsible for producing the votives at the very least, but perhaps also the temple personnel, and other worshippers), and a divine one (in this case the Dioskouroi, who were Greek heroes and saviour gods). The presentation of the votive offering within the shrine was a second performance, made not only for the benefit of the supplicant, but also for the benefit of those around them, whether human or divine. If the votive offering had been made in advance, and this supplication proved successful, this would necessitate a return to the shrine. Once there, a third performance would take place during which a second votive offering (or thank offering) would be presented. According

to Alexia Petsalis-Diomidis, the visual dynamics within the microcosm of a shrine were crucial: the ritual viewing of the cult image and the dedications that had been left there, *θεωρία* (*theōria*), was part of the process by which an individual worshipped, and the display of such votive offerings provided evidence of divine manifestation, demonstrated the deity's efficacy, and was thus central to maintaining the deity's prestige and ensuring future worship (Petsalis-Diomidis 2006, 187–88). In a very real sense, the shrine was a theatre, its interior the stage upon which the supplicants performed for their human and divine audiences, and then once they had finished, the votive offerings they left behind would serve as a constant reminder.

The fact that Aline engaged a manufacturer of artificial limbs (and thus perhaps even anatomical votives) to maintain the shrine indicates that one of its purposes (if not its sole purpose) was to serve as a healing shrine to those afflicted with physical injuries or disabilities (Bliquez 1996, 2640–76; Rose 2003; Vlahogiannis 2005, 180–91). In addition, the fact that Areios offered to waive payment for his services if Apollonios wrote to him personally indicates that Aline had at least discussed the possibility of financial remuneration with him; the shrine of the Dioskouroi was clearly intended to be a public and at least semi-professional enterprise, as opposed to a private one with access restricted to members of Apollonios' family and household only. Perhaps Areios

hoped to make more money from the sale of his anatomical votives to devotees than he would otherwise have done from claiming a wage for maintaining the shrine, or perhaps he had other reasons for refusing payment, possibly political or ideological ones. Thus, having encouraged Apollonios to respond to Areios' offer, Aline concludes her discussion of the shrine, updates him about the welfare of their children and reminds him to write to them all. The end of the letter is lost.

P. Giss. 20: the Social, Economic and Political Contexts of Healing Practice

First and foremost, Aline's actions had a religious dimension; she seems to have sought advice about something from the Dioskouroi (perhaps in the form of posing a question to an oracle) and was subsequently instructed by them (or, as is more likely, the personnel at their temple) to proceed with the dedication and construction of a shrine of her own. The practice of approaching an oracle in the hope of receiving an answer to a pressing question was very common in Egypt during the Roman period, particularly with regard to matters related to health (Frankfurter 1998, 145–56). One example of an oracle question from the Arsinoite nome and dating from the second or third century AD addresses Isis, a goddess particularly venerated for her skill at healing: 'Lady Isis! If you have caused my misery, and if you can give me a cure, please make sure that this note is brought back to me!' (*SB 12: 11226*). Thus it is clear that Aline held the Dioskouroi in high regard; not content merely to worship them at a pre-existing shrine, she made the decision to dedicate and construct a shrine of her own and presumably went to a lot of trouble and expense to do so.

Privately owned shrines were not unusual during the Hellenistic and Roman periods; for example, an official letter sent from a village scribe to a royal scribe in Kerkeosiris and dating to 13 November 114 BC lists the property of a man arraigned for murder: 'I report that he owns the sixth part of the shrine of the Dioskouroi in the village, on the north and east a canal, of which the total value is one talent of copper' (*P. Tebt. 1.14*) (Frankfurter 1998, 74–77). If the Dioskouroi were particularly popular in the area where Apollonios owned substantial property, this may even have necessitated the building of an additional shrine (perhaps dedicated solely to healing) to supplement the pre-existing one. Egyptian priests and priestesses were not restricted to one temple; for example in a census return from Oxyrhynchus that dates to the early first century AD, Orion states that he is a priest of Isis, but he also serves at the shrine of the Dioskouroi within the Sarapeum (*P. Oxy. 254*). It was common for religious personnel (particularly in rural areas) to divide their time between different temples and shrines as the need arose; for example, in a letter from Oxyrhynchus dating to either the second or third century AD, a priest writes to one of his subordinates: 'To the priestess who bears the basket in Nesmeimis, greeting. You will do well to go to Sinkepha to the temple of Demeter to perform the usual sacrifices on behalf of our lords the emperors and their victory and the rise of the Nile and the increase of the crops and the healthy balance of the climate' (*P. Oxy. 2782*). So it is probable that while Areios manned and maintained the healing shrine, any religious rituals that occurred there would have been undertaken by the priest or priestess of a nearby temple or shrine.

Apollonios the Strategos and the Jewish Revolt

Apollonios had attained the position of *strategos* of the Apollonopolites Heptanomia as early as 12 June AD 114. During the Hellenistic period, *strategos* had been a military title akin to that of general, as Alexander the Great's and Ptolemy Soter's respective occupations of Egypt had been military ones and they had put their generals in charge of individual nome districts. By the Roman period, however, *strategos* had become an administrative title, and thus Apollonios had overall responsibility for the civil administration of the district. Then in AD 115 a Messianic leader known variously as Loukuas and/or Andreias surfaced in Cyrene. The uprising that he started there rapidly spread to Egypt, Cyprus and Mesopotamia, evolving into a revolt against Roman rule and a war of destruction and attrition against the Gentiles (Tcherikover and Fuks 1960, 225). It is possible to gauge the scale of the war (or at least Roman perceptions regarding the scale of the war) from the accounts of it which survive from antiquity. According to Cassius Dio, writing nearly a century later, '[the Jews] would eat the flesh of their victims, make belts for themselves of their entrails, anoint themselves with their blood and wear their skins for clothing; many they sawed in two, from the head downwards; others they gave to wild beasts, and still others they forced to fight as gladiators' (*Roman History* 68.32.1–2). Orosius, writing nearly three centuries later, offered a marginally more measured account, stating that 'the Jews acted as if turned into mad savages. Throughout Libya they waged pitiless war against the inhabitants and caused great desolation by killing the tillers of the soil' (*History Against the Pagans* 7.12.6). Ultimately entire Jewish communities of the Diaspora were annihilated, and as late as AD 199 the inhabitants of Oxyrhynchus were still holding an annual festival to commemorate and celebrate the Roman victory over the Jews (*P. Oxy.* 705).

As *strategos*, Apollonios was required to take up arms against the rebels, and it is clear that he took his responsibilities seriously; a letter sent to him from Aline in the summer of AD 115 suggests that the *strategos* could have faced some fierce fighting. She writes: 'I beg you to keep yourself safe, and do not go into danger without a guard. Do the same as the *strategos* here, who puts the burden on his officers' (*P. Giss.* 19). It is clear that the fighting was bloody; one papyrus dating to between June AD 116 and January AD 117 details how the rebels gained the upper hand in Hermopolis, resulting in civilians having to combat them until a Roman legion arrived: 'The one hope and expectation that was left was the push of the massed villagers from our district against the impious Jews; but now the opposite has happened. For on the 20th, our forces fought and were beaten and many of them were killed' (*P. Brem.* 1). The rebels were eventually defeated at Memphis later that year, at a battle in which Apollonios took part (*P. Giss.* 27, AD 117, Hermopolis).

Apollonios' personal involvement in the Roman campaign against the Jewish rebels, combined with the participation of numerous local residents (whether as part of a levied and organised militia or on a more *ad hoc* basis) provides both him and his wife with a strong motivation for dedicating and constructing a healing shrine that could be utilised by members of the local community who had been wounded (perhaps even permanently disabled) as a result of fighting during the course of the Jewish Revolt. In addition to the administrative (and, during the period of the Jewish War, military)

duties required of him as *strategos* of the district of Apollonopolites Heptanomia, Apollonios also owned a large amount of property in and around Hermopolis and a linen-weaving business that employed between twenty and fifty people. Consequently, the combination of his wealth, position in society, and business interests essentially required him and other members of his family to act as patrons to members of the local and even regional community, which they did through the engagement of architects, engineers, builders, and carpenters to design and construct buildings, and also through their linen-weaving business. Such stimulation of the local economy was crucial in the period after the Jewish Revolt, as not only had many people died, but extensive damage had been done to land and property throughout the district and elsewhere. On 28 November AD 117, Apollonios wrote to the prefect of Egypt, Rammius Martialis, requesting sixty days of leave to be spent cleaning up the mess that the revolt had made of his own property: 'Not only are my affairs completely uncared for because of my long absence, but also, because of the attack of the impious Jews, practically everything I possess in the villages of the Hermopolite nome and in the metropolis needs my attention' (*P. Giss.* 41). One papyrus containing the results of a survey of various pieces of land recorded 'open lots, in which there are buildings burnt by the Jews' (*P. Oxy.* 707, early second century AD, Oxyrhynchus), while another, a record of plots of land and houses let to the inhabitants of the village of Sebennytyos, noted that even thirty-four years after the end of the revolt, certain areas were still devastated and 'unfruitful' (*BGU* 889, 27 March AD 151, Fayum). In addition to the documentary evidence, archaeological excavations undertaken on the site of Hermopolis Magna indicate that substantial remodelling took place in the middle of the second century AD (Spencer 1984; Bailey 1991; Alston 2002, 238–42).

The situation in the Hermopolite nome immediately after the Jewish War also offers an alternative explanation for Aline and Apollonios' choice of the Dioskouroi as their shrine's patron deities. If they were concerned about connecting the shrine to a local god or goddess, they could have honoured Hermes/Thoth as the patron god of Hermopolis and the Hermopolite nome, or, if they had always intended their shrine to serve as a healing sanctuary, a Greek healing deity such as Asklepios, or one of the Egyptian healing deities such as Sarapis and Isis, might have been preferable. However, one of the attractions of hero cults was the fact that heroes were perceived as being able to help on a more personal level, since they had once been mortals who had consequently experienced the difficulties of living a human life, and would perhaps therefore be more sympathetic. While the Dioskouroi were frequently worshipped as heroes and also as saviour gods (particularly by sailors and those who had survived shipwrecks) they were also associated with military matters, particularly miraculous victories (such as those that Apollonios and the other local veterans of the Jewish War had achieved). The Dioskouroi were, quite literally, brothers in arms, and any potentially divisive sibling rivalry was discouraged by praise of their different qualities: 'Castor, tamer of horses, and Polydeukes, good with his fists' (*Iliad* 3.279; *Odyssey* 11.300) (Bremmer 2008, 67). The choice of the Dioskouroi was a means of encouraging unity and family loyalty within a fractured community, and the fact that they were apparently already particularly popular in the area in question would only have made the shrine itself more popular and, potentially, more effective in the eyes of those who visited it.

Conclusion

Even the smallest village in Roman Egypt had some sort of religious institution, whether an entire temple complex or a simple privately-owned shrine. It is clear that some gods and goddesses were more frequently worshipped with regard to health and healing than others, and their cults developed accordingly. Perhaps the most famous healing cults in Egypt during the Roman period were those of Sarapis and Isis at Canopus, Sarapis being particularly celebrated for his healing of eye complaints while Isis' assistance was sought for issues relating to women's fertility and conception. The town's close proximity to Alexandria combined with its pleasing situation on the Mediterranean coast ensured that it was visited by a succession of prominent Romans, and the particular association of Canopus with health and healing is evident throughout the Roman Empire. Temples dedicated specifically to Sarapis 'in Canopus' (ἐν Κανώβῳ) are known from Corinth, Delos, Athens, Epirus, Rome, Beneventum and Carthage, while medicinal remedies produced at Canopus (or at least marketed as such) were sold as far away as Gaul (Boon 1983, 10). Also popular was the cult of Asklepios, although in Egypt the Greek god was associated with Imhotep, the fabled architect of the Great Pyramid of Giza, and incubation rituals akin to those that took place at Epidauros were frequently undertaken there.

Pearson and Shanks surmise that 'one of the principal ambitions of interdisciplinary approaches to performance and the past must surely be the discernment of performed behaviours in antiquity' (2001, 68). The healing shrine of Apollonios and Aline served as a theatre for a range of different types of performed behaviours and performative acts that incorporated diverse elements of religious ritual and perhaps even healing practice. Apollonios and Aline were performing for the Dioskouroi, for the Dioskouroi's cult personnel, and for the Dioskouroi's devotees. Areios, the manufacturer of artificial limbs and possibly even anatomical votives, was likewise performing not only for the Dioskouroi, their cult personnel, and their devotees, but also for Apollonios and Aline, his patrons. The devotees, whether familiar faces from the local area or pilgrims from farther away, were performing for the Dioskouroi and their cult personnel, and also for each other, and were leaving offerings that could stand in for them and continue (or at least reference) these performances once they had departed for home. All of these different performances were integrated: Apollonios and Aline provided the stage and Areios provided the props that not only facilitated the devotees' performances for the Dioskouroi, but fundamentally underpinned them.

The dedication and construction of a healing shrine by Aline, wife of Apollonios the *strategos* of the district of Apollonopolites Heptanomia, was not only a religious act, but also a social, economic and even political one. It not only demonstrated Apollonios and Aline's religious devotion to the Dioskouroi, gods that appear to have been particularly influential in the local area, but also their devotion to the local community and its members in the aftermath of a long and damaging conflict. In point of fact, the local community's devotion to the Dioskouroi, heroes and saviour gods particularly associated with military matters and miraculous victories, may well have increased in this period as a direct result of the conflict and its legacy.

Throughout, Apollonios and Aline were acting as patrons; to the architects and

builders who would have been contracted to build the healing shrine, to Areios, the manufacturer of artificial limbs and anatomical votives who was contracted to maintain the shrine, and to any other temple personnel who would have been required to run the healing shrine. However, they were likely also acting as patrons to those members of the community who were suffering from physical injuries and perhaps even permanent disabilities acquired during the course of the Jewish Revolt. Thus, the healing shrine not only served as a means of healing specific individuals, but also the wider community.

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4. Disease, Sin and the Walking Dead in Medieval England, c. 1100–1350: A Note on the Documentary and Archaeological Evidence

Stephen Gordon

Introduction

A ‘revenant’ is a term which denotes a particular classification of ghost. The Icelandic sagas used the word *draugr*, Eastern European folklore preferred *vampyre*, but these terms describe essentially the same, basic phenomenon: a fleshy, pestilent corpse which terrorised the living. Although much scholarship has been undertaken with regard to the Icelandic (Ellis Davidson 1981; Sayers 1996; Lecouteux 2009) and Eastern European (Barber 1987; Keyworth 2010) accounts of the walking dead, the later medieval English iteration of this phenomenon does not seem to have provoked much in the way of academic debate. Nancy Caciola (1996), Jacqueline Simpson (2003), Carl Watkins (2007) and John Blair (2009) have worked to redress this imbalance in recent years, but with accounts of the walking dead in medieval literature restricted to scant, but tantalising passages in chronicles, satires and preachers’ manuals, their potential for study cannot be fully realised if focus is placed on the historiographic and penitential sources alone. Similarly, recent archaeological volumes on ‘deviant’ or non-normative burials have only made passing comment on the evidence for necrophobia, the fear of the dead, in the High and Late Middle Ages (Murphy 2008). A more syncretic approach to medieval revenant belief, one which includes an analysis of written sources, unusual burial practices and the general understanding of disease causation can, I argue, open up further avenues of debate.

Investigations into the Early Modern ‘vampire epidemic’ have often noted the pestilent nature of the walking corpse (de Ceglia 2011, 496; Tiziani 2009, 134). However, the correlation between the outbreak of illness and the agency of revenants has often been overlooked in medieval scholarship. Despite numerous studies being conducted on the relationship between bodily and spiritual corruption, it has never been discussed in the context of encounters with the undead (Grmek 1998, 241–58; Slack 1992, 1–20; Touati 2002, 179–201). It should be stressed, however, that the purpose of this chapter is not to explore all aspects of revenant belief, but to focus on a *specific* articulation of what is an often vague and multivalent phenomenon: the infectious nature of sin. The twelfth to fourteenth centuries, a period which witnessed the formalisation of Purgatory and reconsiderations about the sanctity of the body, can act as a useful framework through

which the maintenance, rejection, or transformation of the belief in the contagiousness of revenants can be analysed (Bynum 1991, 239–97).

Part one of this chapter will analyse the differences between ‘good’ and ‘bad’ death performances. With reference to one of the most notable documentary sources for English revenants, William of Newburgh’s *Historia Rerum Anglicarum* (Stevenson 1861 [1198]), part two will examine the extent to which a percipient’s educational background, their conception of the sinful body and knowledge of medical theory influenced the ways in which they understood ‘bad’ death and the agency of the deceased. The chapter will conclude with an example-led investigation of the archaeology of revenant belief, using William’s *exempla* as a template to examine the material evidence for the assuagement of pestilential corpses.

Indeed, in order to fully understand the everyday conceptions of ‘bad’ death, we need to look beyond the liturgies and preachers’ manuals and focus on the residues of *everyday* practice, a glimpse of which can be seen in William’s narratives and the archaeological record. Practice theory – specifically, the work of the cultural theorist Michel de Certeau – is a useful methodological tool for explaining how the general ideas about death and dying in the medieval period were interpolated and reconfigured in local contexts (de Certeau 1980, 1984). While it is not the remit of this paper to provide a full account of de Certeau’s formulations, it suffices to state that practices may vary, and different types of innovation can be made, depending on the mental, material and environmental possibilities (or structures) available to the percipients at a particular moment in space/time. Variations in the burial rite were carefully thought-out innovations of practice, in which prevailing ideas about the body, sin and disease could be reused in contexts where the death performance went so awry that a new, contingent practice was needed. Thus, using a combination of documentary and material evidence, this chapter will illustrate how smaller (practical, unwritten) defences against pestilent bodies could be improvised within the larger (written, authoritative) traditions of the funerary performance to form idiosyncratic patterns, or ‘rhetorics’, of apotropaic response. However, before the investigation can turn to unusual or ambulatory practices, an analysis first needs to be conducted on the conception of ‘good’ death in the later Middle Ages.

Good and Bad Death

The evolution of the Western medieval funerary rite has been the subject of much scholarship in recent years (Rowell 1977; Rutherford 1980; Paxton 1990; Wieck 1999; Thompson 2004). Suffice it to say that the ideal Christian death in the later Middle Ages occurred in the death bed, with the dying having confessed and received absolution from the priest (Rutherford 1980, 53; Thompson 2004, 57). The *Commendatio Animae*, the dedication of the soul to God, was uttered by the priest at the moment of death. The conduct of the deceased was also paramount to a good death performance, in that he or she should have welcomed death in the manner of Christ; a expectation which became more overt in the early fifteenth century with the production of the *Ars Moriendi* tracts (Ducloew 1999, 379–429). Following death, the body was sewn into a shroud and taken to the church, where the Office for the Dead was performed over the body. Vespers would

be performed by the priest on the evening before the Requiem Mass. A nightwake was sometimes held, in which the priest would recite prayers over the body as it rested in the church. Matins and Lauds were conducted the following morning. Following the Mass, a further blessing of absolution was said over the corpse, and the body was taken to the graveyard (Gilchrist 2005, 23–24). Coffined and un-coffined burials were equally common in this period, although a greater percentage of the latter were found in local or pauper graveyards. The mortuary rites ended with the deceased being blessed by the priest and deposited in the ground (Rowell 1977, 65). If this brief overview represents the ideal or ‘base’ pattern for a good death performance, one which ensured the integrity of the deceased’s soul and their potential salvation come the Last Judgement, what if death did not follow this plan?

‘Bad’ death was sudden, violent and ill-prepared, leaving the living unable to satisfy the conditions for a successful rite of passage. Otherness, and the contravention of the prevailing *habitus* of the community (murder, witchcraft, suicide etc), were also disruptive and acted as further factors in enabling the return of the deceased. The outcast or the unshriven became a form of sin incarnate – something which became even more apparent if their spiritual difference was mirrored by their bodily difference. In other words, the state of the body was seen as a manifestation of the state of the soul. Revenants, then, are material indices of disorder and unrest. To use the terminology of Julia Kristeva, they are a sign of ‘death [chaos] infecting life’, entities trapped in a liminal state between life and death (Kristeva 1982, 4). Descriptions of revenants may vary according to environmental conditions and the expectations of the beholder, but the general observation that they were bloody, bloated and resistant to the natural processes of decay seems to have been a cross-cultural constant (Barber 1987; Tiziani 2009). Decay was one of the greatest signifiers of sin, and a restless, pestilent corpse was an unambiguous reflection of the state of the dead person’s soul. ‘Bad’ death was considered especially polluting and contagious, and needed an extra ritual performance to ‘bind’ the deceased, heal the social schism, and restore order to the community. This belief can be discerned over a wide geographical and chronological spectrum, in both folk and authoritative contexts. The ecclesiastical acknowledgment that such beliefs existed is exemplified by a passage from Burchard of Worms’s *Corrector* (c. 1025): ‘when any child has died without baptism [the townspeople] take the corpse of the little one and place it in some secret place and transfix it with a stake [lest it] arise and injure many’ (McNeill and Gamer 1965, 339). Burchard may have condemned this practice, ascribing a penance of two years to anyone who ‘has done, or consented or believed this’, but it nonetheless affirms the unnaturalness (and thus fear) of a death that did not follow the expected pattern. The warning found in John Mirk’s *Festial* (c. 1380s) that lecherous and unrepentant thieves should be buried ‘neyther in chyrch ne in chirch-3orde’ suggests that dying ‘badly’ was considered as polluting in the late fourteenth century as it had been in the eleventh (Erbe 1905, 297–99).

Sin, Disease and the Walking Dead in the *Historia Rerum Anglicarum*

It must be stressed that it is difficult to determine how far the ideals of the Church filtered down to everyday lay practice, or the extent to which everyday habits influenced

the structure of canon law. It is unlikely that the complicated deathbed rituals, discussed above, were replicated at all levels of society. However, it is feasible that the written evidence concerning the body, damnation and salvation, in conjunction with the ingrained local fears about the post-mortem activities of the dead, may have inspired the variations of practice which occurred at the grave-site. Considering the ambiguity of much of the extant material evidence, it is difficult to discern when innovations to the 'ideal' funerary rite constituted extra protection for the living instead of extra benefits for the dead. Was the special attention given to the corpse a way of protecting the deceased's integrity for the Resurrection (good death) or was it a way to 'bind' a potential revenant to the grave (bad death)? Are local medieval burial performances mindful of the need to both help *and* distance themselves from the dead?

Answers to such questions do not reveal themselves easily. Without contemporary written accounts of unusual or deviant burial practices, the interpretation of the archaeology is fraught with speculation. Thus, it is to the extant documentary evidence, specifically the ghost narratives contained in William of Newburgh's *Historia Rerum Anglicarum* that this investigation first needs to turn. William, a canon at Newburgh priory, North Yorkshire, was approached in 1196 by Ernald, the abbot of the nearby Cistercian monastery of Rievaulx, to write a history of English affairs from the Conquest to the present day. Contained within this history is a collection of twenty-five stories on the prodigious and supernatural. Four of these tales are noted by William as being so inexplicable as to be devoid of precedent in the annals of written Christian history:

It would be strange if such things should have happened formerly, since we can find no evidence of them in the works of ancient authors, whose vast labour it was to commit to writing every occurrence worthy of memory; for if they never neglected to register even events of moderate interest, how could they have suppressed a fact at once so amazing and horrible, supposing it to have happened in their day

(Book V, chapter 24.1)

As their sobriquets – the Buckinghamshire Ghost (chapter twenty-two), the Berwick Ghost (chapter twenty-three) and the Hounds' Priest and the Ghost of Anantis (both chapter twenty-four) – suggest, these narratives deal with cases of the dead who wandered from their graves 'to the terror or destruction of the living' (V.24.1). Pointedly, these four tales are placed between an account of a heretical uprising in London instigated by a peasant named William Longbeard (chapter twenty and twenty-one), and warfare between France and England which, says William, led to heavenly punishment through famine (chapters twenty-five and twenty-six). For the purposes of this paper, only two of these stories will be analysed in detail: the Ghost of Anantis and the Buckinghamshire Ghost.

The Ghost of Anantis tells of a 'certain man of evil conduct' who, after fleeing from York, became part of the retinue of the Lord of the Castle Anantis (Alnwick) and married within the household (Simpson 2002, 391). According to local rumour, the man's wife was not the most virtuous of women. Indeed, one night, after pretending to leave the castle, the 'man of evil conduct' hid in the bedroom and caught his wife 'in the act of fornication with a young man of the neighbourhood'. Enraged, he fell from the beams where he was hiding, vowed to exact punishment on his wife and, critically, failed to make confession before succumbing to his injuries. True to his word, the man's

body emerged from the tomb each night, accompanied by a pack of howling dogs and a terrible, pestilent stench. Many people died from the plague. Finally, two young brothers decided to exhume the errant corpse. They found it grotesque and swollen, with a ruddy, blood-soaked face. Realising that the corpse must be a ‘blood sucker’ (*sanguisuga*), they removed the heart before burning the body on a pyre. Having taken this action, the pestilence which had so gripped the town was no more (V. 24. 4–7).

The Buckinghamshire Ghost narrative begins with William recounting the fate of a man who died and was buried on the feast of the Lord’s Ascension, an event which can be dated to Thursday May 30, 1196. However on the very next night he returned to his bedchamber and attempted to ‘lie upon’ his wife in the marital bed. This occurred for three consecutive nights, after which the dead man started accosting livestock and other people in the village, spreading further chaos and discontent. The matter was taken to the archdeacon, Stephen, who in turn consulted St Hugh of Avalon, the archbishop of Lincoln. The bishop was as amazed as everybody else (*episcipo vero stupente super hoc*), but was told by some of his advisors that such things often happened in England, and that the usual remedy was to dig up the body of whoever was causing the nuisance and cremate it. This solution seemed both unseemly and sacrilegious to the bishop, and so he instead prepared a scroll of absolution and told the archdeacon to place it on the dead man’s chest. So doing, the revenant walked no more (V.22.1–2).

The above narratives reveal a number of fascinating details about the interrelationship between sinfulness, disease and the walking dead. The use of the phrase *sanguisuga* (one of the first known metonyms for vampire in either Latin or the vernacular) did not emerge in a vacuum, and suggests that the fear of the blood-sucking revenant had been circulating in the local *habitus* for generations before making an appearance in the literary arena. Moreover, it is noticeable that the revenants in each *exemplum* exhibit remarkably similar qualities: the Buckinghamshire Ghost’s assaults spread like a contagion, while the pestilence that accompanied the Ghost of Anantis affected almost the entire town. As a historian, William had the responsibility seek the ‘truth’. Truthfulness, however, came in a variety of guises. Exactitude (correct chronology), universality (an ideal truth or model) and plausibility (the extent to which information correlated with the prevailing worldview of the community) were the three main definitions of truth as understood by medieval historians (Given-Wilson 2004, 2–6). Although William himself says that revenants do not follow a universal model (‘it would be strange if such things should have happened formerly, since we can find no evidence of them in the works of ancient authors’), they are certainly exact and plausible according to the schema laid out above. There is also no doubt that the transcription of these *exempla* served a moralistic – that is, a universally ‘truthful’ – purpose (Bynum 1997, 13–15). Thus the changing conception of sin and disease intimated by these *exempla*, and how this led to innovations in how the pestilent dead were contained, may indeed reflect the beliefs of the everyday populace; beliefs that, admittedly, were filtered through the constraints of genre and William’s own worldview. Before an analysis of the Ghost of Anantis narrative can begin, it should be reiterated that in the Middle Ages the macrocosm (the universe; the physical world) and the microcosm (humanity; the moral world) were considered to be inextricably linked.

The universe affected social agents as the agency and intentions of agents affected the material, physical world. Humoural theory, which gained greater exposure in twelfth-

century Europe following an increase in the number of Greek and Arabic medical texts that were being circulated in the West, explains how everything in the universe was made from the same constituent parts: coldness/wetness/dryness/hotness, the combination of which determined a person or object's complexion, or state (Nutton 1995, 139–213). Thus, internal sin (which was a destabilisation of the spiritual equilibrium of man brought on by the Fall) and decay and disease (which were destabilisations of the material universe) were linked. Decay is sin, and sin is decay. The Christian concept of the contagiousness of sin is expressed most clearly by St Paul: 'A small amount of yeast spoils the whole batch' (1 Cor. 5: 6). William takes up this theme most explicitly in his condemnation of the *Publicani* (Cathar) heretics, an insidious sect who spread their infection and pestilence throughout mainland Europe: 'These [people] spread the poison of their heresy, which had originated from an unknown author in Gascony, in many regions; for such numbers are said to be infected with this pestilence throughout the extensive provinces of France, Spain, Italy, and Germany...' (II.13.1). Thus, William's able use of the sin/disease metaphor must be taken into account when attempting a moral reading of the agency of the undead.

The unnamed revenant from Anantis died 'badly' in that he succumbed to a sudden, ill-timed death and did not confess his sins. Although Augustine (c. 354–430) taught that the dead themselves could not return, this did not preclude the possibility that a sinful and thus unfortified body could be infiltrated and given agency by demons. William's statement that 'issuing, by the handiwork of Satan [the Ghost of Anantis] wandered through the courts' is certainly testament to the influence of Augustinian teachings (V.24.5). Indeed, Caesarius of Heisterbach's *Dialogue on Miracles* makes explicit the belief that sin, which was made manifest in decay and the destabilising smells of the revenant, could only overtake a body that was complicit in its own infection (Caesarius of Heisterbach 1929 [1220], II, 334–35). Considering that these narratives appear between stories of a heretical uprising in London and warfare on the Continent, William is obliquely stating that the pestilence exuded by the revenant only affected those who were already predisposed to be so – those who were already weak of faith or corrupt in some way. These narratives, then, can be interpreted as subtle criticisms of the social turmoil that was occurring in England and France at the time. William Longbeard (the peasant leader) and the Kings of England and France were also acting like revenants in that they, too, were seen to be spreading disease and discontent. Longbeard's 'powerful conspiracy [...] organized in London, by the envy of the poor against the insolence of the powerful' infected the 'idiot rabble' and coerced them into treason (V.20.4–5). Likewise, the 'famine [which] vehemently afflicted the people of France and England' was said to have increased in response to 'the disputes of the kings amongst themselves' (V.26.1).

Although it may have had its origins in a distant, pre-Christian past, the cremation of the 'blood-sucker's' corpse was a practice which was entirely consistent with the prevailing beliefs of the day (Caciola 1996, 31–32). Prior to the advent of Purgatory (1274), the maintenance of the integrity of the corpse was paramount for a successful resurrection at the Last Judgement (Thompson 2002; 2004). Since there was as yet no doctrinally approved 'third place' (Abraham's bosom and Limbo were two of the places where the soul was believed to reside after physical death), the deceased was sometimes said to retain a sort of vestigial personhood in the grave. These habits of belief could

be reconfigured and reused in situations where the 'good' death performance went so awry that a new, contingent practice was needed. The destruction of the body prevented the spread of pestilent humours, contained the agency of the demon and, if the wicked themselves were believed to inhabit the body, ensured their damnation.

Cremation, then, was the practice considered most in keeping with the appearances of the sinful dead. To understand why, in the second narrative, Hugh placed a scroll of absolution on the corpse's chest, we need to understand how and why the bishop's perception of death differed from that of the villagers. Hugh was a Carthusian monk who became bishop of Lincoln in 1186. According to his two great biographers, Gerard of Wales (1146–1223) and Adam of Eynsham (c. 1150–1233), Hugh was a great advocate of Church reform, especially with regard to the salvation of the soul and the care for the dead, going so far as to bury strangers he found lying in the road (Loomis 1985, 19–20). Accordingly, Hugh's theological school at Lincoln attracted some of the greatest thinkers of the age. The school's chancellor, William de Montibus, was a native of Lincoln, but studied in Paris alongside Peter Comestor and Peter the Chanter, theologians who were among the first people to define Purgatory as a bounded, physical place where the dead could benefit from the suffrage of the living (McKinnon 1969; Le Goff 1984). Although belief in a middle-place between life and death had existed since before Gregory the Great, the end of the twelfth century was the time when, according to Le Goff, the concept began to gain wider theological acceptance (Le Goff 1984, 157).

Hugh's Carthusian upbringing and the progressive theology of William Montibus must surely have structured the Bishop's understanding of the restless dead (Watkins 2007, 187). Indeed, Hugh's reaction to the revenant encounter may be indicative of someone immersed in a different experiential culture to the Buckingham villagers, and who, after having searched through his own past experiences and theological beliefs, had to find a new, innovative response to an event which existed on the very periphery of his worldview. Hugh, then, chose to grant the corpse absolution rather than send it to the flame. The Word of God was considered exceptionally powerful, and was used in all manner of magical rites outside of official liturgies (Flint 1991, 301; Kieckhefer 1998, 126–53; Fanger 1999). Physically inscribing a prayer of absolution ensured that its power could 'work' beyond the immediate context of an immaterial blessing. Again, it can be seen how practices which formed part of a larger tradition could be reconfigured depending on individual, or material, circumstances. However, it should also be stressed that the possibility of confronting the walking dead was something that both Hugh *and* the villagers, as members of the wider Christian community, believed to be true. Hugh may have been initially surprised by the petition, but the dangerous ambiguity of the cadaver and the abject nature of decay were issues which were never in doubt. Divergence occurred in the type of sinful body each group perceived. For a people untutored in the learned ideals emerging from France, and perhaps still allied to centuries-old habits, cremation was a perfectly reasonable technique for assuaging the walking dead. With ideas about Purgatory giving the dead a newfound freedom to walk the earth once more, revenants could no longer be perceived *solely* as demons-in-disguise. Sin, in the form of physical and/or spiritual corruption, could now signify the possibility of redemption as well as damnation. Absolution, suffrage and prayer could be just as efficacious as flame.

The Archaeology of Disease: Responses to the Sinful Dead

William of Newburgh's narratives provide an insight into how local English populaces might have perceived, understood and assuaged the dangerous dead. They also show how modifications to the prevailing social structure opened up new strategies for rectifying the problem of 'bad' death. But can any of the practices mentioned in these *exempla* be discerned in the archaeological record? To what extent does the extant material evidence reflect the need to keep sin – that is, disease – contained?

To help answer these questions, it should be noted that the rate in which the corpse succumbs to decay (and thus the way it perceived upon exhumation) was contingent on a variety of environmental and biological factors. Bodies subjected to sudden or ill-timed deaths decompose at a different rate to those that died 'well'. The sudden removal of oxygen from the body, for example, is said to prevent the coagulation of the blood, preserving the ruddiness and bloodiness of the corpse beyond what would be considered 'natural' (Glaister 1916, 186; Barber 1988, 114). Head trauma, drowning, suffocation and disease are events which entail the *unnatural* disruption of the body's physiological system (Barber 1987, 8). Swollen, florid corpses were thus incredibly problematic. Not only did they confirm the 'badness' of the individual's death, but, once risen, their dangerous, destabilising miasmas had the potential to do wider social and environmental damage (Palmer 1993, 61–68).

References to 'pestiferous' vapours overtaking the local community are a frequent occurrence in William of Newburgh's *exempla*, suggesting that epidemics did much to structure the perceived agency of the revenant (V.24). Evidence for the types of disease that were prevalent in medieval England, such as malaria (Gowland and Western 2012), plague (Fay 2006, 198), and tuberculosis (Roberts and Manchester 1995, 135–42), can be discerned through an examination of the osteological data. Tuberculosis, most commonly identified by joint degradation and lesions on the spine, is an affliction which seems to have forged the closest relationship with the belief in roaming corpses (Roberts and Manchester 1995, 137–38). The propensity of the walking dead to accost both humans and livestock is a common feature of Icelandic *draugr* narratives and may, perhaps, be a rationalisation of the disease's ability to transmit between species via the inhalation of infected air or the ingestion of tainted meat and dairy products (Hight 1978, 93; Roberts and Cox 2003, 40). The attribution of the symptoms of tuberculosis to the agency of the revenant is made much more explicit in nineteenth-century accounts of the New England 'vampire' epidemic (Sledzik and Bellantoni 1994). Victims of consumption were said to retain their freshness in the grave by feeding on their kin, who, having wasted away, followed their family members into death. In a manner which echoes the treatment of the wayward corpse in William's Ghost of Anant narrative, it was believed that the only way to break the connection between the living and the dead was to remove the blood-sucker's heart and cremate it (Sledzik and Bellantoni 1994, 270).

Archaeological examples of cremation are difficult to determine, especially since the ashes were often 'scattered [...] to the winds' (V.24.3). Even in cases where tuberculosis was the known cause of death, the likelihood of discovering material analogues for the removal of the heart is negligible (Sledzik and Bellantoni 1994, 272). Although more archaeologically viable strategies, such as prone burial, staking, decapitation, weighing

the corpse with stones, and deposition in liminal areas of the landscape, intimate a fear of the agency (and materiality) of the corpse, they have yet to be securely linked with signs of disease, illness, and the fear of contagion, and will thus be set aside for the purposes of this paper. The following section, therefore, will review the practices which seem to focus solely on efforts to mitigate the problems caused by the ‘pestiferous breath’ of ‘foul carcasses’ (V.24. 5). Word limits are going to restrict the discussion to what I contend are three of the more overt medical/magical strategies for dealing with the dead: ash and charcoal burial, the use of ‘binding’ amulets, and the deposition of scrolls of absolution in the grave-fill.

Charcoal and Ash Burial

In general, the spreading of ash or charcoal on the bottom of the coffin or grave-pit can be seen as a positive innovation of the burial rite. The use of ash in this way seems to derive from the *Life of St Martin of Tours* written in the fourth century, and built upon throughout the Middle Ages. According to the hagiographer Jacob de Voragine (d. 1298), Martin told his followers that ‘the only way for a proper Christian to die is in sackcloth and ashes. If I leave you any other example, I shall have sinned’ (Ryan 1993, 298). The great liturgical writer of the thirteenth century, Durandus of Mende (c. 1230–1296), also talks about this practice in a positive light, stating in the *Rationale Divinorum Officiorum* that the body of a dead monastic should be placed on a bed of ashes for ‘the body [was] ashes and shall return to ashes’ (Rowell 1977, 65). If the action of lying upon burnt, reduced material can be seen as a form of penitence prior to death, only a small innovation is needed to extend the concept of laying the dying man on a bed of ashes to lining the grave with the same substance.

However, a closer inspection of the penitentials suggests that on a local level, the deposition of charcoal or ash may have been a way to bind the dangerous body to the grave. Roberta Gilchrist has discussed how a decree found in the tenth-century *Confessional of St Egbert* (‘Anyone who burns corn in the place where a dead man lay, for the health of living men and of his house, should do one year of penance’) could be evidence of the Church’s disdain for unsanctioned innovations to the liturgy; an example of how non-Christian practices and fears were still a part of the local habitual schema (Gilchrist 2008, 145). Indeed, as the burial data from the churchyard of St Peter’s, Leicester, demonstrates, the lining of the grave with burnt or otherwise reduced material was an especially long-lived popular practice. Charcoal was spread in the grave lining of the double burial Sk. 681/682 (Fig. 4.1), one of twelve examples from St Peter’s of a body management strategy that reached its zenith in the eleventh and twelfth centuries (Daniell 1997; Gnanaratnam 2009, 123).

The deposition of a bed of ash within the coffin was a later innovation, with the St Peter’s examples (of which there were thirteen) dating to the fourteenth century (Gnanaratnam 2009, 131–32). It is hard to discern whether these were post-mortem acts of penitence, as Durandus of Mende intimates, or long-lived, habitual responses to a body that had the potential to rise. The possibility that such acts had a dual protective and redemptive function cannot be discounted. Charcoal is known to be a useful material



Figure 4.1. Double Charcoal Burial SK681/682. Churchyard of St Peter's, Leicester. Dated c. 1100 (courtesy of University of Leicester Archaeological Services)

for soaking up bodily fluids and, if ingested, is believed to reduce swelling (Jones 2002, 49). The medicinal use of burnt material can be traced as far back as Bald's *Leechbook*, a medieval miscellany produced in the tenth century but that can trace its origins to the court of Alfred the Great (Cameron 1983). The reduction of 'goats flesh' into ashes, for example, was used in a remedy against 'swelling' (Cockayne 1865, 73; recipe i.xxxi.3). Recipe ii.xxiv notes how the burnt remains of 'twigs' or 'stalks of coleswort' should be ingested as part of a remedy against liver disease (Cockayne 1865, 215). The act of ingestion is also noticeable in mortuary contexts. The discovery of charcoal/ash in the oral cavities of skulls in the cemetery of Norwich Greyfriars has been interpreted as a sign of penance – a spiritual salve against such verbal sins as heresy. (Gilchrist and Sloane 2005, 79).

Thus, if unstable fluids are a sign of abjection and sin, then the practice of lining graves with burnt material can also be seen as a symbolic apotropaic response to bodies that did not follow the 'correct' mode of decay. Bloating and swelling signified restlessness,

a disrupted pattern, and needed to be managed accordingly. If we consider the popular belief that the decaying flesh was the epitome of disease (indeed, Egbert himself notes that people burnt corn for the ‘health’ of the house) then it is feasible that sinners who had the *potential* to become revenants were managed using similar medical/magical rhetorics. This idea is made much more explicit in the form of ‘binding’ charms.

‘Binding’ Disease: A Long-Lived Practice?

The *Lacnunga*, an Anglo-Saxon medical miscellany dating to the eleventh century, contains numerous charms which illustrate how ligatures were seen as powerful devices for curing (or ‘binding’) physical and spiritual ailments (Grattan and Singer 1952). Although the evidence that the medico-magic practiced in the Anglo-Saxon period survived the upheavals of the Conquest is scarce, the late twelfth-century copies of the *Old English Herbarium* and *Peri Didaxeon* suggest that Anglo-Saxon medieval traditions which did not contravene the prevailing structures of the Anglo-Norman society could continue to circulate – and thrive – in the *habitus* of the local populace.

At first glance it is difficult to determine why binding was considered such an effective apotropaic technique. Recourse to the anthropological literature can provide at least some sort of explanation for the practice. To paraphrase the conception of magic as articulated by Alfred Gell, the power of magical substances resides in the inability of the viewer to comprehend the ambiguous properties of an object or thing’s creation (Gell 1998). Abstract forms such as ligatures, weaves and difficult incantations are said to bewilder the senses; since such patterns are difficult to process (that is, they are ambiguous with no readily understood form) they can never be fully inferred. Thus the object of the bind, the agent of disease, becomes ‘trapped’ or ‘stuck’ in the pattern (Gell 1998, 85–90). For instance, charm CLXVIIIc, which details that one must ‘write this [scriptural passage] on a vellum sheet as long as many surround the head, and hang it on the neck of whatsoever man needeth it’, is just one of many recipes in the *Lacnunga* that utilises binding and/or labyrinthine invocations in some way (Grattan and Singer 1952, 189). Although Gell’s research was primarily concerned with contemporary Polynesia, Valerie Flint’s thesis on early medieval magic would seem to confirm the former’s ideas on the power of ambiguous objects and difficult invocation (Flint 1991). Even in the later Middle Ages, Galenic physicians such as John of Gaddesden (c. 1280–1360) were aware of the popular belief in the power of ‘knots’, specifically the use of ligatures to cure ailments such as toothache and gout. As Gaddesden himself writes in his *Rosa Medicinae* (c. 1314), ‘some say that the beak of a magpie hung from the neck cures pain in the teeth and the uvula and the quinsy’ (Cholmeley 1912, 49). If the meanings attributed to certain objects can be transferred from one social context to another, then the practice of tying ligatures to curtail disease may be extended to include bodily and spiritual disorders that were made manifest in the grave-site.

Jet pendants, quartz, fossils, hazel staffs, pilgrim badges and jewellery are among the types of grave good that have been interpreted as providing magical protection for the dead (Gilchrist 2008). Roberta Gilchrist (2008, 149–50) and Christopher Knusel (1995, 380) have theorised that attempts to ‘heal’ the body in the grave were also achieved

through the use of copper ligatures. To posit a slightly different reading of the material, the presence of ligatures may also reflect efforts to 'bind' the flesh of a swollen – and potentially restless – corpse. Excavations from the churchyard of St Marks in Lincoln, for example, revealed a late eleventh-century skeleton whose upper arm was wrapped in a spool of copper alloy wire (Gilmour and Stocker 1986, 41). The Black Death cemetery at East Smithfield, London, contained the body of an adult male (grave 7166) with a copper link wrapped around the base of the tibia (Grainger 2008, 16). Sk.121 from St James's Priory, Bristol, was buried with a fragment of copper alloy under its left knee (Jackson 2006, 79). Classical and insular medieval traditions – the latter perhaps influenced by the former – both believed that copper was able to reduce acute pain, swelling and infection. Indeed, it has been theorised that the primary function of the copper plates attached to the leg of Sk. 251 from the cemetery of St Andrew's, York, was to treat an ulcerated knee-joint (Knüsel 1995, 381). Even today magnetic copper bracelets are used to treat arthritis, and modern medical science has shown that copper is indeed toxic to certain bacteria (Dollwet and Sorenson 1985; Brennessel *et al.* 2005, 186). As illustrated above, the curative effects of ligatures were an entrenched facet of local belief in this period. Thus, a device that was protective and beneficial in life, such as the St Andrew's truss, may have afforded a similar level of protection in death. Dangerously swollen bodies needed to be contained lest fears about their spiritual and physical status arise. A copper bandage or truss was a type of improvised grave good – an amulet – that benefited the living *as well* as the deceased. If uncontrolled decay can be taken as a sign of sin, then the protection of the body using magical binds and metals was a way of curtailing signs of restlessness and maintaining the spiritual/physical integrity of the corpse. This is not to suggest that protection against the restless dead was the definitive function of ligatures – indeed, it is equally possible that carelessness during the act of deposition accounted for a significant number of the extant finds – but that the habits and beliefs associated with an artefact in one context (the assuagement of 'disorder' in life) may have influenced its use in another (the assuagement of 'disorder' in death).

Scrolls of Absolution

The Buckingham Ghost narrative has demonstrated how scrolls of absolution were another form of grave good that could be used against the restless dead. Another documentary example can be discerned in the second of the twelve ghost stories transcribed by an anonymous Byland Abbey monk at the end of the fourteenth century, suggesting, perhaps, that the granting of absolution to errant corpses was a long-lived, albeit sporadic, practice (Grant 1924, 363–79). The Byland narrative details the travails of a tailor, Snowball, who was attacked by a shape-shifting ghost as he walked home one evening. The haunting only ceased when the tailor obtained a scroll of absolution from a local priest and placed it in the revenant's grave (Grant 1924, 368). Like the Ghost of Anantis, this ghost was also pestilent; the tailor was noted by the anonymous monk as being 'seriously ill for several days' after the encounter (Grant 1924, 369). Considering that the ghost admonished the tailor for being in possession of items belonging to his kin – 'You are keeping wrongfully the cap and coat of one who was your companion

and friend' – and in light of the commonly-held belief that an unbalanced and sinful body was susceptible to further invasion by malign agents, it can be seen why the tailor was so susceptible to the revenant's pestilence (Grant 1924, 369).

Archaeological analogues for the use of absolution scrolls in this manner are scarce. The evidence that can be discerned, however, would seem to corroborate the events described by William and the Byland Monk. The lead parcel found upon the abdomen of a woman from St James's Priory, Bristol (Sk.60), may be one such example. Fragments of parchment were discovered within the folds of the parcel, suggesting that it may have once contained a prayer similar to that written by Hugh of Avalon (Gilchrist and Sloane 2005, 200). It is equally possible that a lead sheet discovered in a fourteenth-century grave in Croxton Road cemetery, Norfolk – hitherto interpreted as an off-cut – was also an intentional deposit (Wallis 2006). Lead was seen to possess magical, affective powers (Merrifield 1987, 138–40). Coffins made out of this material preserved the corpse and prevented the leakage of potentially destabilising smells and fluids into the environment. Wrapping the Word of God in a lead parcel may have been seen to magnify and *preserve* the scroll's own affective properties and allowed the prayer to work over a longer period of time. Although this act can be viewed as a way of delivering the deceased's soul from their purgatorial torments and ensuring their entry into paradise, the actions of Snowball and Hugh of Avalon have shown that the power of the Word could be put to a parallel use of allaying restless bodies. This confirms the hypothesis that in certain times and certain situations, scrolls of absolution could be employed as apotropaic devices to protect the living *from* the dead. Read in this way, the lead parcel surrounding the St James's Priory parchment was able to preserve the efficacy of the prayer until the flesh decayed and the body was rendered 'safe'.

Conclusion

This chapter has offered a brief review of the ways in which the pestilent dead were perceived and managed in England during the later Middle Ages. The sinful nature of decaying flesh was a serious concern for the medieval Church, and I would argue that the ways in which revenants were perceived and contained demonstrate different conceptions, and different fears, regarding the process of keeping the contagious forces of sin at bay. To echo de Certeau, different ways of 'moving through' and subverting one's immediate perceptual environs created different rhetorics, or patterns, of belief (de Certeau 1980, 16). Although the codification of Purgatory in 1274 seemed to displace the corporeal ghost in favour of its spiritual counterpart – that is, more canonical focus was being laid on the state of the soul instead of the state of the body – the idea that the dead could return from the grave remained, and thus the *possibility* of confronting a revenant lived on in the *habitus* of daily life. An anecdote from the *Armburgh Papers*, dating to 1432, which mentions how '[Richard Baynard] felle downe and dyed with owte howsill and shrifte and anon after he walkyd' provides tantalising evidence that the belief in revenants persevered into at least the fifteenth century (Carpenter 1998, 62).

Circulating within these entrenched mental schemas was the belief that the act of binding was central to the containment of spiritual and physical disease. From this

base, habitual understanding of the universe emerged a variety of possible rhetorics, including cremation, the lining of the grave with ash/charcoal, and the use of affective grave goods. Cremation is the ultimate ambulation of the 'good' burial rite and is thus the ultimate abstraction, or bind (Gell 1998). At their core, even such normative practices as post-mortem prayer and burial in consecrated ground reflect a need to protect the living through the correct management (or binding) of the sinful, decaying flesh. In consideration of the prevailing belief in ghosts, demons and revenants in the medieval world, there may be more articulations of this fear in the archaeological record than we currently appreciate. The boundary between life and death, between physical and spiritual disease, may have been a lot more permeable than even the chronicles, liturgies and preachers' manuals would have us believe.

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5. Pilgrimage, Performance and Miracle Cures in the Twelfth-Century *Miracula* of St Æbbe

Hilary Powell

In the medieval West healing and performative acts were inextricably linked. These performances could range from the recitation of charms to unlock the latent supernatural forces residing in herbs and other natural substances, to grand apotropaic rituals performed by entire communities. Such healing performances found their fullest expression within the context of pilgrimage. Visits to shrines to access the healing powers of the saints were inherently performative acts in which saint, supplicant and audience each played a well-defined role in the familiar drama of the miracle cure.

The principal source of evidence for these performances is hagiographical texts; the accounts of the lives of the saints and the posthumous miracles they performed. Contained within these texts are the performative cues that directed the ritual behaviour of pilgrims approaching the shrine to seek a cure; whether it be to approach on their knees or an altogether more complex set of directions, these texts prescribed a series of ritual acts which the supplicant should undertake in order to receive a miraculous cure. Moreover, these texts, by prescribing the performance of these rituals, attempted to engender both in the pilgrim and in the wider audience an understanding of the divine nature of the healing received at the shrine.

This essay will illustrate this through an examination of the *miracula* of St Æbbe, an Anglo-Saxon abbess whose relics were rediscovered in the twelfth century near the monastery of Coldingham in the Scottish Borders. This text delineated a series of healing foci in the local landscape through which pilgrims should pass before receiving their cure, but it also located this landscape within an explicit biblical context which underlined for the listener the ultimate spiritual source of their healing.

The *Vita et miracula S. Æbbe* survives in a single manuscript, Bodleian Library, MS Fairfax 6, fos. 164^r–173^v (Bartlett 2003). This is a collection of chronicles and saints' *vitae* written at Durham during the second half of the fourteenth century (Madan, Craster and Denholm-Young 1937, ii. 773–75). The text itself dates to the final decade of the twelfth century since it mentions the dedication of an oratory in 1188 (Bartlett 2003, 31). It was written at Coldingham for the brethren at Durham by a former inmate of the cathedral priory:

The venerable presence of the body of our holy father Cuthbert supports you ... Whenever I consider this, I pine for my own land like a wanderer and a stranger. I, who cannot participate in your glory, therefore fly to the protection of St Æbbe ... I am sending to your holiness the little gift of a sermon about her life and miracles ...

(cited in Bartlett 2003, 3)

The priory of Coldingham was a daughter house of Durham. Originally just a monastic grange, substantial endowments by Scottish kings, ecclesiastics and magnates in the early twelfth century necessitated a permanent monastic presence to oversee Durham's large and prosperous Scottish estates (Dobson 1967, 2). Monks serving the church of Coldingham appear in the documentary record in 1139 and the first reference to a prior dates to 1147 (Barrow 2003, 153). By the mid-thirteenth century Coldingham had become the wealthiest and most prominent of all of Durham's eight daughter houses. The proposal, c. 1235, that there should always be thirty resident monks (besides the prior) at Coldingham, compared with seventy at Durham, suggests the priory had considerable resources (Dobson 1967, 2; Easson 1976, 55). Like several of Durham's dependent foundations, namely Jarrow and Wearmouth, Farne and Lindisfarne, Coldingham was located near the site of an earlier Anglo-Saxon religious community. In his *Historia Ecclesiastica*, Bede refers to the double monastery of *Coludi Urbs*, where Æbbe, aunt of the Northumbrian king Ecgrith (670–685), presided as abbess during the seventh century (Colgrave and Mynors 1969, 392, 420–26). The monastery, however, was short-lived since it had been destroyed by fire by the time Bede was writing in 731. Excavations conducted in 1980 by Leslie Alcock (1986) revealed a possible site for the Anglo-Saxon monastery on the top of a nearby headland, known as St Abb's Head. Despite the lack of institutional continuity between the early medieval community and the later priory, the monks were keen to forge an identity which harked back to the heyday of Anglo-Saxon Christianity. The chance discovery of a sarcophagus containing the body of the Anglo-Saxon abbess occasioned great rejoicing for the brethren of the newly founded priory (Bartlett 2003, 23). Although the priory held extensive lands within the local region, these were recent acquisitions and they, the English monks, were foreign settlers. The recovery of Æbbe's body and its subsequent enshrinement in a reliquary on the high altar of the priory church bestowed not only the kudos which came from possessing a saint, but an air of legitimacy; in choosing to reveal herself to the brethren, Æbbe, the local patroness, had conferred her support on the Benedictine community.

The Coldingham monks were keen to establish the cult of St Æbbe. From the reign of King David I (1124–1153) grants of land were regularly made out to the blessed Mary and St Cuthbert, the two dedicatees of the priory church. From 1182, however, Æbbe joined the triumvirate, suggesting that her name had been added to the church dedication (*ibid.*, xxii). Of greater importance, however, was the composition of the *Vita et miracula S. Æbbe*. The modern editor of this text, Robert Bartlett, claims that its composition was 'part of a campaign to secure her [Æbbe's] reputation as a saint', a means of challenging sceptics and silencing naysayers and thus was an instrument by which the cult was established (*ibid.*, xxvii–xxviii). The idea that texts possess agency is not a recent one; the active role of texts such as these has long been supposed. Miracle narratives are frequently assumed to have had a propagandist function, written expressly for the purpose of advertising the shrine's power and promoting it

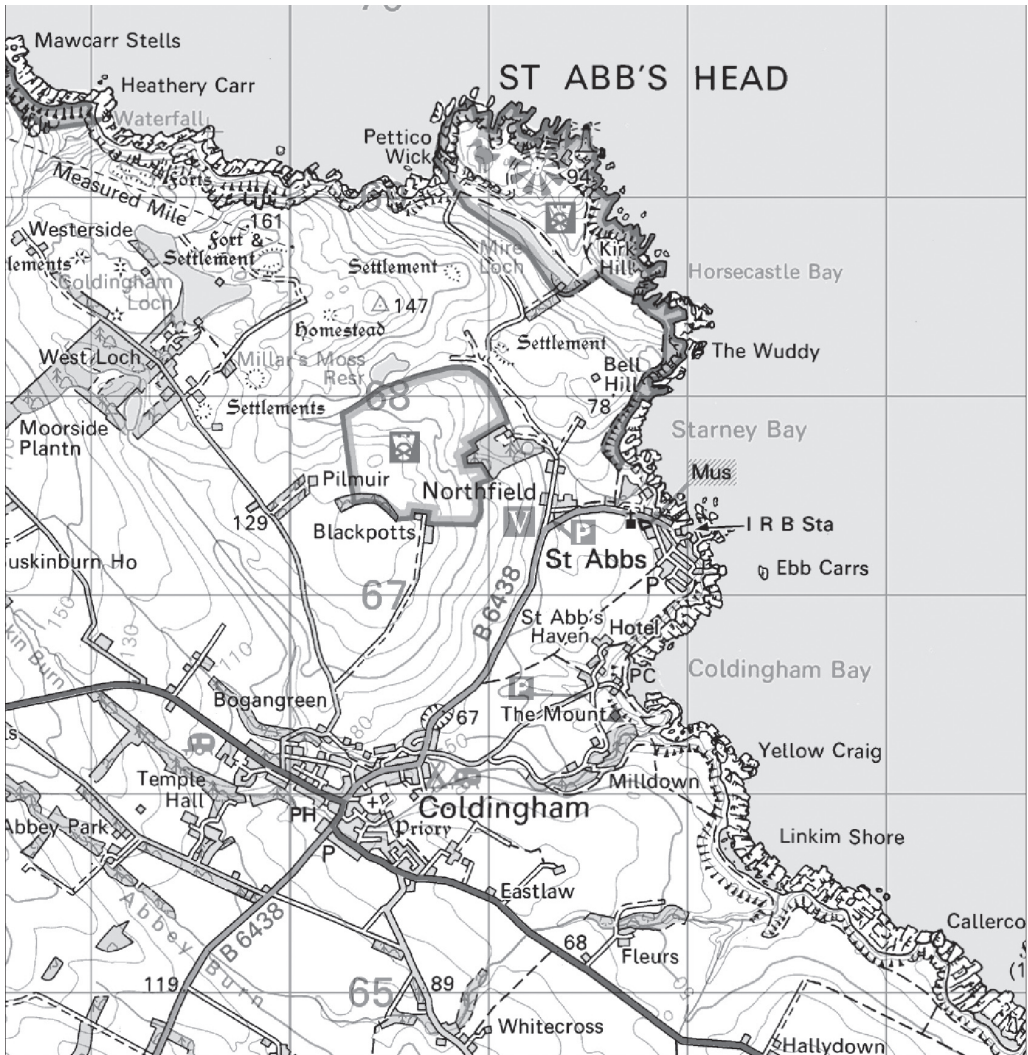


Figure 5.1. © Crown Copyright 2014. Ordnance Survey 100054416.

as a pilgrimage destination (Ward 1987, 166). While these texts may indeed have been constitutive of social practices, a subject to which we will later return, they could not conjure a cult from nothing. As Rachel Koopmans (2011, 5) observes:

Since written records of the [miracle] stories are all we have left, it is tempting to read the writing as making or sustaining cults, but a cult did not need a text, and a text could not make a cult. Cults were orchestras of voices that could not be conducted, swarms of stories that shrank and expanded according to their own internal and often mysterious rhythms.

We must assume that Coldingham was already a pilgrimage destination, perhaps not to the extent depicted in the *miracula* where throngs of people are mentioned, but certainly busy enough to supply the author of the *miracula* with enough stories to draw upon (Bartlett 2003, 39, 43).

The *Miracula S. Æbbe* is typical of the genre, being comprised of discrete narratives and containing factual details such as age, gender, domicile, occupation and medical condition. Appeals to the testimony of witnesses and to the swearing of corroborative oaths generate the impression of accurate, truthful descriptions of genuine experiences. Appearances, however, are deceptive. Far from being mute repositories of pilgrim testimonials, miracle narratives contain authorial voices. The monastic hagiographers charged with writing these texts would have listened to the stories and then written them up in accordance with their own rhetorical and ideological strategies. Although there are several plausible candidates, including Reginald of Durham and Geoffrey, sacrist of Coldingham, the author responsible for the *Miracula S. Æbbe* has still to be conclusively identified (*ibid.*, xvii–xx). Yet, despite this deficiency, his agenda emerges clearly from his text.

For the majority of pilgrims eager to solicit Æbbe's help their goal was not the saint's reliquary which stood on the altar of the priory church, nor her tomb also located in the church, but a tiny oratory perched on the top of the nearby headland overlooking the sea. It was here that Æbbe would almost invariably appear and heal those keeping nocturnal vigil. Of the forty-two miracle cures enumerated in the *miracula*, thirty-four are located at the oratory, while just six occur at the site of her tomb (*ibid.*, xxv). Although the pilgrims might subsequently return to the priory church to give thanks and relate the story of their miraculous cure, the oratory was clearly the focal point of Æbbe's cult. The author's concern to locate the cult centre at the headland is understandable given the priory's interest in associating itself with the Anglo-Saxon past. Modern archaeologists (most recently Stronach 2005) might disagree as to whether it was the precise location of the original monastery or not, but this matters less than the fact that it was believed to be so in the twelfth century. The brethren of Coldingham priory clearly thought that the monastery of *Coludi Urbs* had been built on top of the headland. The anonymous author consistently describes the rocky promontory two miles north-east of the priory as either *mons Colludi* or *urbs Coludi* and names this as the place where the tomb containing Æbbe's body had been discovered (Bartlett 2003, 23). The oratory was originally a rather modest structure, erected from mud and roughly hewn rocks by a local man named Henry who claimed to have been carrying out orders he had received during a vision. Once miracles began to proliferate, however, the monks, who initially had scoffed, tore down Henry's crude effort and constructed a new, larger chapel on the same site (*ibid.*, 27–31). In 1836 A. A. Carr wrote that the walls of the chapel (now known as St Abb's Kirk) 'and a small Saxon arch, were to be seen till within these few years, between three and four feet in height, upon an elevated mound near the eastern extremity of the wild headland, and close to the very verge of the precipice' (Carr 1836, 243). Later accounts describe a two-cell chapel with a chancel measuring 21ft by 24ft (6.4m by 7.3m) and a nave measuring 56ft by 30ft (17m by 9.1m) (MacGibbon and Ross 1897, i. 437). It was here, in this cold, remote chapel that the pilgrims would spend the night awaiting their miracle cure.

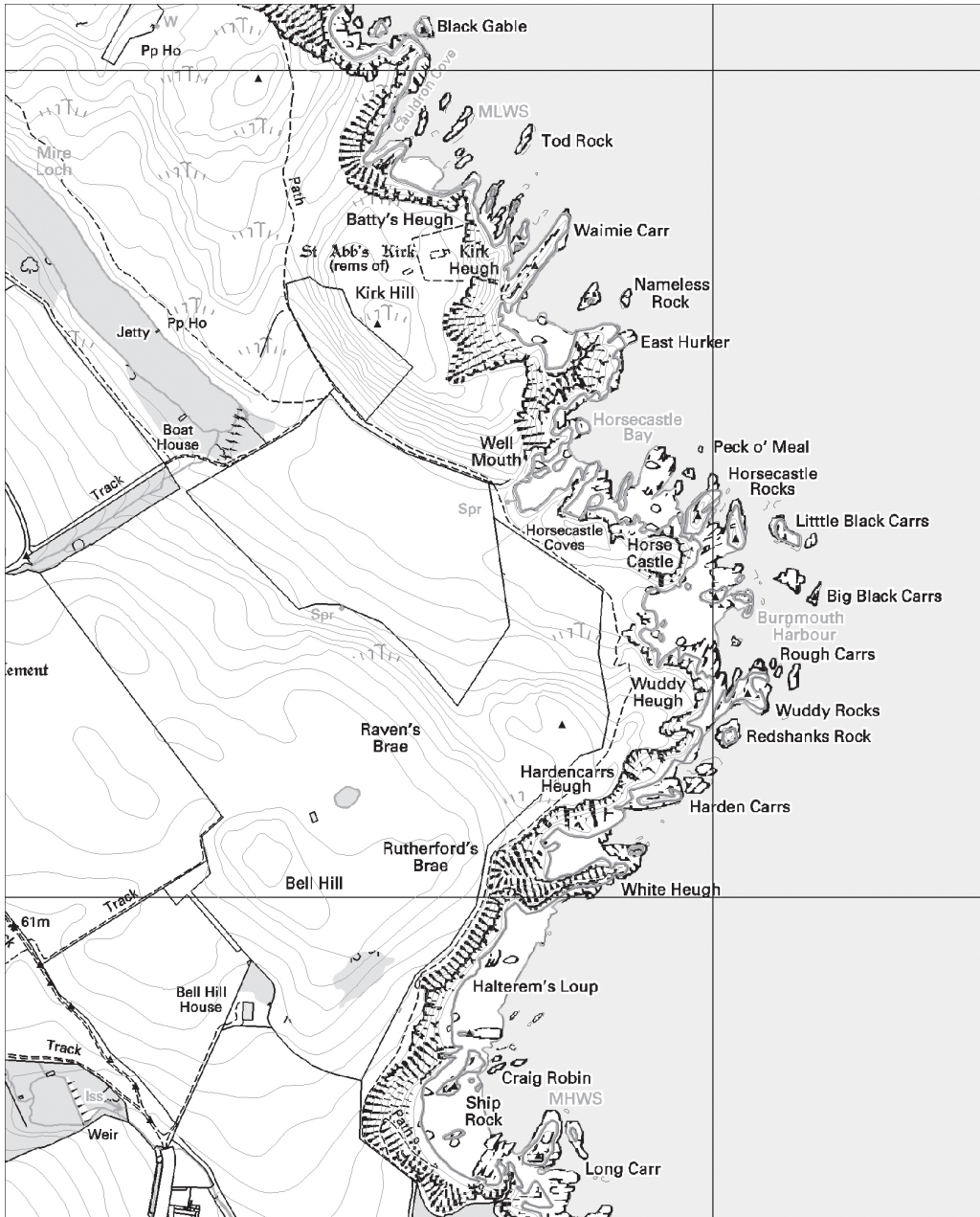


Figure 5.2. © Crown Copyright 2014. Ordnance Survey 1000054416.



Figure 5.3. Looking across the marshy valley at Kirk Hill (Photo: Hilary Powell)



Figure 5.4. Kirk Hill from neighbouring Bell Hill (Photo: Mick Knapton)

It is unusual enough for a miracle collection to seek to deflect attention from both the saint's tomb and corporeal remains, the typical targets for pilgrim devotion. Yet, of greater interest is the emphasis placed on the physical performance of the pilgrimage. The author is concerned not only to locate the cult at the oratory on the headland but to delineate a prescribed route through the landscape. Six of the miracles depict pilgrims drinking and washing in a spring at the foot of the hill upon which the oratory stood (known today as Kirk Hill). They would typically visit the spring and then visit the oratory. One miracle recounts the story of a young girl who had lost her voice following a demonic attack:

Coming to the fountain which the local people call the fountain of the blessed Æbbe, she washed her mouth and face. Immediately it seemed that the blessed Æbbe placed a finger in her mouth and straightaway the bond of her tongue was loosed ... Coming at once to the oratory of the blessed Æbbe, she spent the night there in vigils and prayers

(Bartlett 2003, 63)

Another describes a local man who had a piece of goose bone lodged in his throat. He was advised to try the nearby shrine of St Æbbe: '...he accepted this salutary advice and, rushing up with a swift pace, he drank three times from the fountain which is at the foot of the mountain, he entered the oratory and gave himself up to prayer' (ibid., 35–37). Others who may have dispensed with this stage and proceeded directly to the oratory are instructed through visions of Æbbe to return and wash in the spring. A blind woman guided by her small daughter came to the oratory to pray for her sight. During the night, as she lay sleeping, Æbbe appeared to her in a vision and said to her 'go to the foot of the mountain and wash in my fountain and your sight will be restored.' The woman awoke 'determined to seek the fountain and, going around the mountain and the places below it without anyone to guide her or show her the way, she found it. She washed, the darkness completely dispersed and she received the gift of sight as before' (ibid., 35). Similarly, a young man whose right hamstring was contracted so that his foot had twisted back into his buttocks and worn a channel in the skin was sleeping at the oratory when he was visited by the blessed virgin. He was told that he should go to her fountain and wash the afflicted place. He went down, washed and returned to the oratory whereupon he was revisited by Æbbe and cured (ibid., 57–59). In some cases the order in which these places were visited is unclear. A blind man 'came there led by his wife and, as dawn came up on the third day, when he had anointed his eyes with water from the fountain, as he had been instructed in a dream, he recovered his sight' (ibid., 59). This man had presumably spent the two preceding nights at the oratory where, as with the others, Æbbe had appeared to him in a vision. It was not uncommon for pilgrims to spend two nights in vigil at the oratory before receiving a miraculous cure (ibid., 37, 65).

Reading between the lines of the *miracula* we can see a clearly demarcated system of supplication involving sequential visits to selected *locales*. It was not uncommon for pilgrimage centres to be surrounded by a 'sacralised topography' of chapels, holy wells and wayside crosses. In their anthropological study of modern and medieval Catholic pilgrimage, Victor and Edith Turner (1978, 23) explain that these lesser shrines operate like 'sacred valves', which deliberately impede the pilgrims' progress. These 'resistances

are designed to build up a considerable load of reverent feeling, so that the final ingress to the holiest shrine of all will be for each pilgrim a momentous matter'. In the Middle Ages this 'sacralised topography' was nowhere more evident than in the Holy Land and in the holy city of Jerusalem itself. Although the precise itinerary changed over the centuries according to political circumstances, a variety of sites associated with the life of Christ led the pilgrims to their ultimate goal, the church of the Holy Selpulchre (Wilkinson 1981; Stopford 1994, 60). Such carefully managed ritualised spaces were also evident at other pilgrimage centres. Pilgrims visiting Canterbury cathedral where Archbishop Thomas Becket was murdered in 1170 were channelled past the exact spot of his martyrdom before descending into the crypt to visit his tomb (Robertson and Sheppard 1875–1885, ii. 123, 136). By the late Middle Ages, the Holy House of Walsingham in Norfolk, established after a vision of the Virgin in the eleventh century, was enveloped in a much larger ritual complex which included a chapel of St Lawrence and two holy wells (Hall 1965, 119). At St David's in west Wales, early Christian sites and monuments were consciously co-opted by the promoters of the cult of St David. Keen to improve the prestige of their church and press their claims to metropolitan status, successive hagiographers sought to situate the legend of St David into a local, ritual landscape. Pre-existing cist cemeteries, holy wells, chapels and stone crosses were written into the saint's hagiography, thus binding the saint to the local district and establishing a composite pilgrimage site with multiple foci for veneration (James 1992).

The impression generated from the *Miracula S Æbbe* is of a ritually managed landscape which pilgrims were required to negotiate sequentially. The idea that shrine custodians might seek to regulate the space and dictate the terms by which pilgrims were permitted to engage with the ritual site is not in itself new. Although they were keen to develop a view of pilgrimage as a 'realm of competing discourses' where the shrine operated as a 'religious void, a ritual space capable of accommodating diverse meanings and practices', anthropologists John Eade and Michael Sallnow (1991, 5, 15) nevertheless recognised that 'shrine staff might attempt, with varying degrees of success, to impose a single, official discourse.' The precise means by which this could be achieved, however, are not elaborated upon beyond the acknowledgement that 'their control over the organization of space and time in relation to shrine activities gives officials a considerable advantage over pilgrims in imposing conformity on ritual activities' (ibid., 11). Simon Coleman and John Elsner (1994) sought to remedy this deficiency through an analysis of the experience afforded to pilgrims at the monastery of St Catherine at Mount Sinai. Their phenomenological approach focused on the physical experience of the pilgrimage route, exploring how pilgrims were obliged to encounter the sacred locations around the mountain. They sought to show how 'the physical characteristics of pilgrimage sites can provide a religious topography designed to impose – or at least suggest – behavioural and ideological conformity' (ibid., 74). The capacity for material culture to generate meaning is well-understood; social knowledge is constructed through practice which is circumscribed by the physical fabric of our environment (Graves 1989, 297–301). Material markers such as chapels, prayer niches and mosaics channelled pilgrims through the holy sites of Sinai and served to locate the process of pilgrimage there in a Christian interpretative frame (Coleman and Elsner

1994, 84). Although natural features such as springs and pathways are not strictly speaking material culture, they nevertheless possess an archaeology since they acquired significance in the minds of people in the past (Bradley 2000, 35). Accordingly, like material culture, they define the parameters of social praxis and are hence generative of social knowledge. The prescribed route through the Scottish landscape circumscribed the pilgrims' experience and consequently, informed their spiritual engagement with the site. The questions thus remain: why was this route so prescribed, and what were the meanings it might have engendered?

In addition to demarcating a route, the author of the *Vita et miracula S. Æbbe*, took pains to emphasise its physicality. In the *vita*, the headland is described thus:

There is a rock situated about the sea, round in shape like an egg, its northern face being larger, while to the south its sides slowly converge almost to a point. It rises so high that the favour of nature girds it with its own height and defends it by the rough surroundings. It is connected to the surrounding hills by a very wide valley ... It is hard to climb and hard to reach, for to the north and south it is approached by narrow paths, not without fear of the precipice which plunges downward, while to the west it rises to a peak in a little hill and thence slopes eastwards to an uneven flat surface, where the oratory of the blessed virgin can be seen.

(Bartlett 2003, 9)

Remote and perilous, the headland was hardly an inviting place to visit. Its steep slopes represented a challenge even to the able-bodied; in order to mix the mortar with which to build his oratory, Henry 'carried water, in a little cask placed on the cart, from the foot of the mountain up a rocky path across the side of the steep mountain' (ibid., 33). For those with sight or mobility problems it must have been even more risky and arduous. A man 'crippled in the knees...[who] was not able to get along except by crawling on his hands and knees' came to the oratory 'with great difficulty' (ibid., 63). For another pilgrim who walked bent over with a staff it was a punishing undertaking: 'While one foot moved freely, the heel of the other one was twisted upwards and he had to touch the ground with his fingers, making more of a leap than a step... One Saturday, when people were flocking with haste from the surrounding hamlets to the mountain and oratory, as was the custom, he too began to go and, travelling painfully like a slow tortoise from the ninth hour of the day [3pm] until evening, he at last arrived there' (ibid., 39). The climb to the oratory, though steep and hazardous, was not the only physically demanding aspect of the route. Before the pilgrims arrived at the foot of the mountain they had to cross the wide valley. This in itself was no easy feat. A. A. Carr (1836, 243) described it as having been 'an impassable quagmire'. Moreover Carr notes that when attempts were made to drain the valley at the end of the eighteenth century 'several fragments of oaken timber were dug up, which are supposed to have been the landstools of a draw-bridge by which it had been crossed' (ibid., 244). Pilgrims bound for the oratory would have first had to cross the swampy, waterlogged valley.

Appreciating the physical challenges that pilgrims following the demarcated route would have faced does in fact shed some light on why the route may have been so prescribed. In the *vita* we find an account of Æbbe's flight from Aidan, a so-called 'tyrant of the Scots' who wished to marry her. According to the *vita* Æbbe 'took refuge

ad montem Colludi and that, at her prayers, the sea, raising itself up from the south and overflowing the course of the adjacent valley, for three days obstructed the enemy and provided the protection of a fortification for the virgin, with the Lord's help' (Bartlett 2003, 7). Pilgrims ushered through boggy, saturated ground to the spring where Æbbe and her companions once drank and from thence to the hilltop where she had sought refuge were in essence re-enacting the story in the *vita*. Moreover, the physical participation expected of the pilgrims – picking their way through the mire, drinking and washing in the spring, climbing up the mountain – were mimetic rituals; their performance had the effect of presencing the Anglo-Saxon narrative. By participating in these physical acts, the pilgrim took on the mantle of the saint; as Æbbe had turned to the mountain for her deliverance, they too should look to the mountain and God as the source for their desired deliverance from adversity and affliction.

Performing these rituals, however, did more than make the pilgrim simply mindful of Æbbe and local traditions. In justifying belief in the story of Æbbe's escape the author appeals to two earlier paradigmatic miracles: '... things are believed more easily if they can be supported by a similar happening. For, if I should say that the brimming sea provided a dry path for those carrying St Cuthbert's body, nobody would perhaps believe it, unless they had previously read of a similar work of wonder performed in the Red Sea' (ibid.). The invocation of Moses' parting of the Red Sea (Exodus 13:17–14:29) brings a biblical resonance to the pilgrimage. Æbbe is equated with Moses, her flight from Aidan is the equivalent of the Israelites' flight from Egypt and, by extension, the headland to which she ran is the Scottish embodiment of Mount Sinai, the site of Moses' theophanic experience. The *Vita S. Æbbe* hardly merits the title since it consists of little more than this miracle and a virtually verbatim passage from Bede's *Historia Ecclesiastica* (Colgrave and Mynors 1969, 420–26). Therefore it is primarily through this sole miraculous episode that the author formally advances Æbbe's claim to sanctity. The protection which God extended to Æbbe in flooding the valley to impede Aidan's pursuit was similar to that afforded to the Israelites; this miracle marked her out as one of God's chosen, in short, a saint. Hence, in tracing their route through the landscape, pilgrims would not only be revisiting events from the Anglo-Saxon past, but re-enacting scenes from biblical history.

Once the pilgrims had arrived at the oratory, however, the interpretation of their experience shifted away from a Mosaic towards a Christian dispensation. Of Æbbe's 42 healing miracles, 24 (57 per cent) involve apparitions of the saint and all but one of these visions occurs at the oratory. Æbbe would typically appear to the pernoctating pilgrim as they slept or prayed. Several of the miracle recipients describe her wearing white garments, while to another she appeared in a nun's habit (Bartlett 2003, 35, 41, 61). She often touched the afflicted body part; previously mute pilgrims frequently claimed that she put her fingers into their mouths and released whatever had been constricted (ibid., 43, 49, 51, 63, 67). One man claimed she 'explored with her hands the places where he felt pain, touching them quite roughly' (ibid., 39). Another, however, describes her touch as 'gentle' (ibid., 41). In one miracle she is joined by the Blessed Virgin Mary, in another by St Michael the archangel and in a third by St Margaret of Scotland (ibid., 53–55). She tends to appear in the east: one man 'was standing before the altar, with his heart raised aloft, offering himself and his prayers to the Lord ... [when he was] restored by

the consolation of a joyful vision' (ibid., 45). In one instance Æbbe even appears 'sitting on the holy altar' (ibid., 43). The point is that for pilgrims coming to the oratory, a vision or apparition of Æbbe was a normative part of their healing experience. This is rather unusual in healing miracles. Pierre-André Sigal examined over two thousand accounts of posthumous healing miracles from eleventh- and twelfth-century France and found only 255 miracles, or 12 per cent, featured saintly apparitions (2007, 134, 255). The fact that Æbbe is seen by her pilgrims is highly significant. Indeed, the author comments: 'It is amazing and a remarkable thing in miracles, that she who wished to heal wished also to be seen manifestly and recognised by her whom she healed' (Bartlett 2003, 49). Æbbe's visual manifestations are a clear departure from the Mosaic symbolism found in the *vita* since they bring to mind not Moses' sacred encounters, but the Transfiguration of Christ. The Transfiguration was a vision received by three apostles, Peter, James and John, on the top of Mount Tabor. They witnessed the incarnate Christ transfigured into his divine nature and speaking with the two Old Testament prophets, Moses and Elijah (Matthew 17:1–12; Mark 9:2–9; Luke 9:28–36). Whereas Moses' and Elijah's theophanic experiences on Mount Sinai had been audial as opposed to visual (in Jewish theology, God cannot be seen), the watching apostles received a vision of the incarnate Godhead (Exodus 33:12–23; I Kings 19:9–14). While in the *vita* Æbbe was a figuration of Moses, in the *miracula* she becomes emblematic of Christ. The pilgrims to whom she appears are thus to join the ranks of the watching apostles, Peter, James and John, who witnessed Christ's Transfiguration.

The message that Christ is the source of the pilgrims' healing seems to be a recurring refrain for the author. Right at the start of his sermon he references the Psalmist by exhorting his listeners to 'look up to the mountains from whence comes my help' (Bartlett 2003, 3; Psalms 120(121):1). Mountains were a well known allegory for Christ: 'in the last days the mountain of the house of the Lord shall be prepared on the top of mountains' (Isaiah 2:2; Micah 4:1). In fleeing Aidan, Æbbe ran towards Christ. The miracle which ensued was directly due to her faith. According to the gospel of St John: 'He that believeth in [Jesus], as the scripture saith, Out of his belly shall flow rivers of living water' (John 7:38). The rising sea which flooded the valley at Æbbe's prayers were the 'rivers of living water'; testimony to her faith in Christ. The overflowing sea made the mountain to which she had run into an island, thus vouchsafing Jesus' declaration that if we believe, we cast the mountain into the sea (Matthew 17:19). The ritual re-enactment of Æbbe's flight gave the twelfth-century pilgrim the chance to publicly and physically articulate their belief in Christ, a chance to quite literally put their own faith into practice.

Embedded in both the *vita* and *miracula* is an interpretative framework for understanding the true source of the healing cures performed at the oratory. It is tempting to suggest that these texts gave pilgrims the intellectual apparatus by which they could make sense of their experience but this, in itself, requires a leap of faith. It presumes the promulgation of the texts among the pilgrim community, a practice for which there is no direct evidence. Research focusing on the reception of Latin hagiography is still very much in its infancy. Although historians have accepted the multi-functionality of the genre and the capacity for a hagiographic text to have sermonic, liturgical and even meditative or contemplative uses this has seldom extended

into a detailed examination of the contexts of its dissemination (Wood 1999, 93). All too often historians have been content simply to recycle the claim that *miracula* were written for edificatory and propagandist purposes without thinking about how Latin texts were disseminated to an (inferred) lay audience. Although the texts occasionally contain anecdotal evidence for monks preaching to the laity on the subject of a saint's life and miracles, recent case-studies have indicated that *miracula* were seldom ever read aloud to a lay audience. Although the manuscript containing the *Vita et miracula S. Æbbe* contains some traces of marginalia, there are no signs that the text had ever been divided into lections for reading during the liturgy. More problematic for our attempt to construct a context for its dissemination at Coldingham is the fact the text was dedicated to the brethren at Durham and that the manuscript containing the sole surviving copy of the text has a Durham provenance (Bartlett 2003, 3). There is in fact no evidence at all to indicate that this text was ever known at Coldingham, much less disseminated to the transient pilgrim community who gathered there.

We must, therefore, not overstate our claims for this text. While it might be tempting to propose that the *miracula* had a reflexive role and helped to establish a paradigm for the ritual behaviour of the pilgrim community, it is impossible to prove. Yet this does not necessarily mean that pilgrims visiting Coldingham were unaware either of the practices they were expected to perform or the spiritual exegesis which underlay them. On the contrary, although hagiographical texts were literary creations, their authorship was complex and multivocal (Coleman and Elsner 2003, 2). The hagiographer may have been responsible for turning experience into words but the stories which he received were already narrative productions which drew on shared linguistic and cultural frameworks. Even before the hagiographer set to work moulding the stories to fit his own agenda, they already would have exhibited, what Coleman and Elsner (*ibid.*, 9) have termed, 'prepatterning, formulaicity and idiomaticity' as the pilgrims, searching for words in which to describe their own miraculous experience, would have subconsciously reached for those of others. Wes Williams (2003, 18) described early modern pilgrims to the Holy Land 'speaking not so much in their own persons, nor on their own behalf, but at others' behests and in borrowed voices'. Most likely, in circulation at Coldingham was a shared discourse communicated orally among the pilgrim community that told of the proper way to negotiate the journey to the oratory and prepare for a miracle cure. Information about the shrine does appear to have spread by word of mouth. One woman came 'on the advice of friends' while another was advised by 'some people in Berwick' (Bartlett 2003, 35, 39).

The crucial question remains however: why was this text, which situated the local Coldingham landscape within a complex exegetical framework, written and sent to Durham? As previously noted the *Vita et miracula S. Æbbe* was written by a former inmate of Durham cathedral priory. As a former inhabitant of the convent, the hagiographer would have been familiar with the claim that Durham possessed the relics of St Æbbe. Symeon of Durham, writing his *Libellus de Exordio* in the early twelfth century, stated that during the early eleventh century the sacrist at Durham, Elfred Westou, had exhumed and translated Æbbe's body to Durham (Rollason 2000, 162–64). Indeed her bones are enumerated in a relic list dating from the first half of the twelfth century (Battiscombe 1956, 113). Yet the *translatio* of Æbbe, sandwiched between the *vita* and the *miracula*

claims otherwise. The author writes: 'Her tomb is in our midst... But ancient tradition had left no certain information for posterity as to whether it contains any relics of the holy body or completely lacks that treasured deposit. They affirmed that her bones had been removed from there and taken elsewhere and that it contained nothing except her veil' (Bartlett 2003, 21–23). 'They' presumably refers to the monks of Coldingham to whom the tomb was taken upon its discovery. One of the brethren managed to break the tomb at the foot and reached in to ascertain what remained. Such impertinence, however, was met with divine punishment and the monk in question was struck by a sudden pain in his limbs. He died shortly afterwards and the tomb was encased in stone. For a long time, the tomb was left alone, but eventually, emboldened by visions of the virgin, the brethren decided to reopen the tomb. When they did:

... they saw dust in the shape of a human body ... When they put their hands in, the shape of dust dissolved. They searched through the dust and found many bones underneath, some of which turned to dust from age and decay in the hands of those touching them, some of which were barely preserved complete. They dried the dust, which had been kept moist until now because of the cold, in the sunshine and sieved it, and collected the bones together, then arranged them all in a new shrine which they placed on the altar where it could be revered worthily. They replaced in the tomb that part of the dust which the sieve had left

(*ibid.*, 25)

The monks at Coldingham clearly believed that they alone possessed the saint's relics: '... If [anyone] contends that the larger bones have been taken away, let him bring to mind the intact dust' (*ibid.*, 27). The author, however, appears to have shied away from directly rebutting Durham's claims and we are left with a rather awkward compromise: 'Others may flatter themselves that they have her holy relics – let them rejoice to have them and be happy to venerate them; let us rejoice that we are not lacking in them and celebrate having touched them with our hands' (*ibid.*).

Relations between Coldingham priory and the mother house of Durham may have been less than cordial. Two papal privileges hint at Durham's concern to enforce their rights over their dependent cell suggesting that there may have been an element of insubordination. Although a prior of Coldingham appears in a writ from 1147, a papal privilege ten years later reserved for the Church of Durham the appointment and removal of all St Cuthbert's monks at Coldingham and the prior 'if a prior be there' (Barrow 1998, 319). A subsequent papal privilege, issued just five years later, makes no mention of a prior at Coldingham but once again reserves appointment and removal of monks there to the prior of Durham (*ibid.*). Nevertheless, the writs of King Malcolm IV (1153–1165) and his successor William I (1165–1214) are addressed to the prior of Coldingham giving the impression that the house enjoyed a certain degree of autonomy in its secular affairs in this period (Scammell 1956, 94). However, far from being a period in which Durham's dependent cells wrested a degree of independence, there are signs of Durham's tightening grip, certainly over its relics and cults. Around the year 1170, Durham deliberately shifted the focus of St Cuthbert's cult to the mother house and away from other centres such as Inner Farne and Lindisfarne which had previously been credited with healing miracles (Tudor 1998, 455). Could concerns regarding Durham's

centralisation of its cults provide a context for the production of the *Vita et miracula S. Æbbe*?

The monks of Coldingham may well have articulated their petition for greater liberty through this text. Their suit, however, was not to be found in their claim to possess Æbbe's relics. Instead, it lay in their situating of the cult in the local landscape. The subtext is evident; no matter where her relics were moved, miracles would continue to take place at the oratory high up on the headland. Whether or not this text was used to prescribe the actions of pilgrims or educate them as to the true significance of their visit to Coldingham, the fact remains that circulating at Coldingham in the late twelfth century was a body of knowledge which advised pilgrims of the correct way in which they should prepare themselves, both physically and mentally, for their long-desired miracle cure. Some pilgrims might have arrived at Coldingham already aware of what was ahead of them. They may have spoken *en route* with returning pilgrims or had their curiosity piqued while overhearing whispered details at another saint's shrine. For others, the news may have greeted their arrival, passed on over dinner in the priory's guest house or whispered during a service in the church. In either case the pilgrims would be required to participate in a series of ritualised performances which involved negotiating a difficult passage through the local landscape in order to prepare themselves for the final ritual act, supplication and prayer culminating in a nocturnal vigil which replicated the experience of Æbbe herself. It was only through the performance of these mimetic acts that the pilgrims could hope to realise their goal, a miraculous cure.

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6. Gendered Attitudes Towards Physical Tending Amongst the Piously Religious of Late Medieval Sweden

Johanna Bergqvist

Introduction

It is today generally agreed among scholars of historical and cultural studies of medicine and health that definitions and understandings of disease are to a large extent culturally dependent, even if there are also biological components involved (e.g. Eyler 2010). Anorexia and leprosy are examples which illustrate how our understandings have varied greatly throughout history. The former has been variously given religious, psychological and medical explanations, while the latter has long had strong moral connotations, which have only relatively recently begun to be replaced by a psychological and physiological understanding (e.g. Bell 1985; Puranen 1986; Vandereycken and van Deth 1996). Understandings of these conditions may also differ within a society depending on gender, as has been the case with anorexia. As the comprehension of the underlying causes of disease has shifted, so too have the ideas of which kinds of ailments actually need or ought to be cured, and which do not. A disease may in certain cultural circumstances have connotations that are not entirely negative, which poses the question of the motivation for treatment. Is treatment always desirable and (socially) beneficial, or can disease be used as a statement, as part of one's self image and as a means of expression? Karin Johannisson has suggested that disease is the existential node in which culture and body meets (1997, 12). Understood in this way, it is not surprising if bodily ailments play an important part in existential issues, such as religious practice and experience; a theme I develop here.

Gender can be defined as a social construction, as opposed to sex, which is a biological feature. Gender is thus intersectionally shaped by other aspects of social identity, such as race, class, ethnicity and occupation (Meskell and Preucel 2004; Voss 2006). The inhabitants of medieval monastic institutions were separated primarily according to their biological sex, but the everyday roles that the inhabitants lived within these environments were also gendered. Moreover, through their very special living conditions, including celibacy, relative isolation from the surrounding world and strong spiritual focus, monks and nuns might be regarded as having genders of their own which differed from the ordinary genders *extra claustrum* (cf. Riches 2002). This implies that gendered conditions which were considered valid inside the institutions may not

necessarily have had full validity in the world outside, and vice versa. The ideas of gendered religiosity discussed in this article and by the scholars I draw upon, cannot therefore be fully transferred to the non-monastic religiosity of ordinary parishioners (cf. Peters 2003, 79).

Gendered differences concerning the relationship between inner experiences and physical expressions of Christian faith have been discussed by several medievalists (e.g. Bell 1985; Robertson 1991; 1993; Beckwith 1996; Ruether 1998; Peters 2003; Bynum 1987, 1991, 1995; 2007). It has been suggested by Bynum and Bell that self-starvation and disease were used especially by women to express pioussness and to elevate their personal spiritual experience, while male piety more often was expressed through rituals and verbal expressions in liturgy and Mass. I take this discussion one step further by suggesting that these gendered attitudes within religious practice may actually have affected what kind of surgical, medical and hygienic treatments were expected by and provided for men and women in monastic institutions.

I do this by looking at medieval monastic material culture in the form of archaeological findings from a number of Swedish Cistercian institutions. I also use written source material in the form of a *Diarium* from the Birgittine double monastery of Vadstena, as a bridge between ideals of continental and western medieval religiosity, as suggested by previous research, and the lived reality at Swedish institutions. The material culture and written data is compared and discussed in gendered terms regarding means of physical care and spiritual expression and experience.

The value and necessity of a multidisciplinary approach to the subject of gender and religion has previously been stressed (Riches and Salih 2002, 2). Still, what is with few exceptions (e.g. Gilchrist 1994; 2000) strikingly absent in previous research is the archaeological approach. The material culture in the form of artefacts related to hygiene and leech craft (by leech craft I here mean the art of healing carried out by *lækir*, or 'leeches'; including general, artisanal practice as well as theoretically learned physic, but excluding solely religious or magical healing) from monasteries has up till now been an unexamined material source when it comes to understanding gendered attitudes to the body in religious milieus. The significance of material culture, as opposed to most written texts or pictures of pious men and women, is that it does not primarily reflect abstract ideals or pious ambitions which may or may not have been executed in real life, but the actual lived monastic experience of the men and women who inhabited these institutions. This approach makes it an invaluable contribution to the ongoing discussions of both male and female monastic religiosity, as well as gendered perceptions of the body and of disease.

The fact that men have written many of the medieval texts about and for holy women raises the question of whose voices are actually heard in these texts. Samantha Riches and Sarah Salih bring forward the necessity for scholars to take this potential difficulty into consideration. They suggest that 'in some cases the topos of the holy woman's access to Christ through her suffering flesh appealed more to male hagiographers than to holy women themselves' (Riches and Salih 2002, 2; cf. Mooney 1994, 34). While agreeing that this is an important point, I recognize in the material culture connected to the tending of the body a potential to expand the discussion further, as it indicates how the everyday lives of these men and women were actually lived.

Cistercian Material Culture of Healing and Hygiene

During the twelfth and thirteenth centuries, a number of Cistercian monasteries were founded in present day Sweden. They represented the first extensive monastic wave in Scandinavia, which lasted until the reformation in the 1520s. A number of them have been extensively excavated during the first half of the twentieth century. These excavations generated a rich archaeological record, revealing the material culture used by the inhabitants of these institutions. The material is now housed at the National Historical Museum of Sweden, and is hitherto only partly analyzed and published (e.g. Swartling 1969; Roth 1973, 1987; Regner 2005; cf. Bergqvist 2013).

The excavations were varied in terms of methodological quality and stringency. For this specific study I have chosen to focus on two particular institutions: the male institution of Alvastra and the female institution of Vreta, both in the province of Östergötland in the southeastern part of Sweden (Figs 6.1 and 6.2). The comparatively high methodological quality of the excavations of these two sites makes the archaeological material sufficiently representative to serve the purpose of this study. In comparing the materials from male and female Cistercian institutions it becomes clear that there were differences within the order, and these differences will be the main focus of this paper. It is important to note that the material from other monastic institutions, in particular the nunnery of Gudhem and the monastery of Varnhem in southwestern Sweden, strongly support the picture derived from the Alvastra and Vreta evidence, but as these sites are somewhat less representative due to excavation methodology, they cannot by themselves serve as a basis for analysis of this kind.

Vreta is considered to be the oldest monastery in medieval Sweden, predating Alvastra. It is debated whether it was originally a Benedictine institution, which later became Cistercian (Nilsson 2010, 35ff). Alvastra was founded by monks from Clairveaux in 1143. Both Vreta and Alvastra were very prosperous by contemporary Swedish standards and enjoyed extensive support from the uppermost strata of society- as high as the Swedish contemporary royal families. The nuns, at least initially, seem to have had a higher social ancestry than the monks (Andersson 2006, 165ff).

The dating of the archaeological artefacts is imprecise, but the Alvastra material is mainly from the late thirteenth to the early sixteenth century, and it seems as if this also applies fairly well to the other materials. The Alvastra and Varnhem monasteries seem to have had infirmaries for the old and ill among the inhabitants of the monastery, and Alvastra may even have had several different spaces for different categories of infirm individuals. It is less certain if equivalent facilities existed for the nuns in Vreta and Gudhem (Bergqvist 2010; 2013, 237ff, 428ff, 440ff, 445ff, 450).

The excavations at Alvastra have resulted in around five times as many finds linked to the tending of the body as the excavations in Vreta. Due to the way the materials were once registered, it is difficult to appreciate the total number of items from the two monasteries, but a search in the digital databases of NHMS suggests there were in total around 27,000 and around 5100 items in Alvastra and Vreta respectively, excluding osteological material and architectural details. When comparing the materials it is thus necessary to bear this in mind. To some extent, the difference in quantity can be explained by the size of the institutions. Alvastra was somewhat larger in terms of the

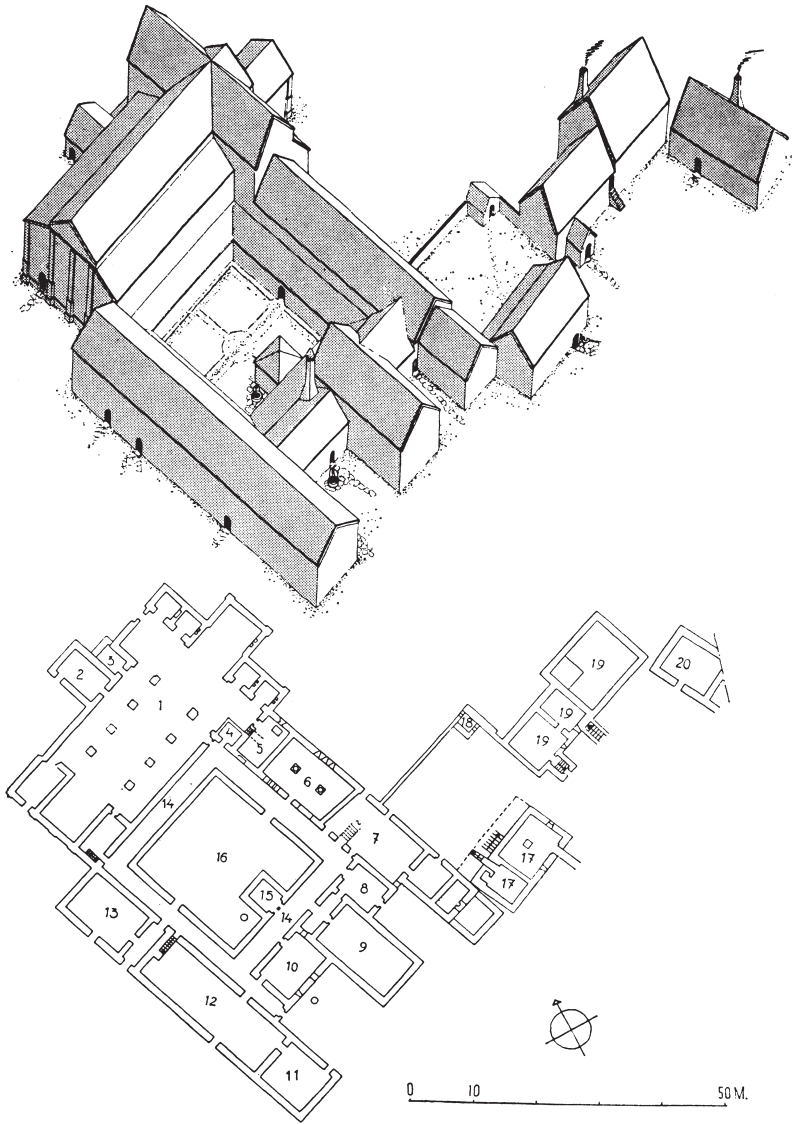


Figure 6.1. Plan of Alvastra (Swarthling 1969).

size of buildings, but not so much in number of inhabitants. The main explanation probably lies in the sheer extent of the excavations and in some differences in the methodologies used concerning the collecting of finds. This seems to have been done somewhat more thoroughly at Alvastra than at Vreta, although particularly interesting finds (including surgical, medical and hygienic equipment) seem to have been rather carefully collected at Vreta as well.

Artefacts particularly related to leech craft and hygiene from the institutions mentioned in this article are numerous in comparison to what has been identified at other institutions in the Nordic countries (compare with e.g. Møller-Christensen and Rousell 1957; Møller-Christensen 1958, 98, 107 concerning Æbelholt in Denmark; Kristjánisdóttir 2008 and pers. comm July 2010, about Skriðuklaustur in Iceland; there is more work in progress on the Skriðuklaustur material, but the number of artefacts is comparatively limited). It is thus an exceptional assemblage and source material. Alvastra has a little more than four times as many artefacts of this kind as Vreta (c. 85:18; although it is not always possible to quantify data – for example, the number of vessels that are represented by a number of glass or ceramic sherds); a difference roughly corresponding to the difference between the sizes of the find assemblages as a whole, when excavation methodologies are taken into consideration. It is therefore not in the quantity of finds that we find the most interesting difference. Rather, it is in the *types* of artefacts represented. In Alvastra we find a much more varied material culture, including glass and ceramic medicine vessels, spatulas, different forms of scalpels (both regular and in the form of clasp knives), different kinds of probes, curettes, fine cautery irons, forceps (non-depilation tweezers), phlebotomy knives, ear scoops and tooth picks. In Vreta the material is much less varied, including only ceramic medicine vessels, a small sharp surgical hook, phlebotomy knives and tweezers (depilation forceps).

What, then, do these items actually represent in terms of treatments? One way to get a more clear picture is to group the artefacts according to function. Doing so is slightly problematic, not least because of the multi-functionality of many items. Still, I have found categorization to be a useful analytical tool. I have chosen to group the artefacts into surgical (cutting and burning treatments), medicinal (mainly not cutting or burning treatments), personal hygiene (preventive personal tending) and bodily domestication (treatments that aimed to discipline the body). An important distinction is thus made between cutting and burning treatments on one hand, and non-cutting or -burning treatments on the other. It is dubious whether practitioners in Swedish secular society made any clear distinction between the two during the Middle Ages. Rather, the so-called *lækir* (leech) did both (Bergqvist 2013, 192ff, 255ff). But, within the monastic milieu, the separation is all the more relevant, due to the church's prohibition against the regular clergy performing cutting and burning treatments from the twelfth century onwards. The monasteries also seem to have followed a more scholastically oriented healing tradition than the rest of society, in which the division between surgery and medicine was more prominent.

The group of surgical instruments consists of scalpels, a cautery and a surgical hook (Fig. 6.3), and the group of medicinal items of vessels, spatulas for applying medicaments, probes for inspecting deeper wounds, forceps for, for example, removing items from wounds (non-depilation tweezers) and curettes for cleaning fistulae and wounds (Fig. 6.4). I also include phlebotomy knives in the medical category, as the theoretical motivation for bleeding lay within the medical field (Fig. 6.4). Phlebotomy has been discussed by Megan Cassidy-Welch (2001, 147) as a means to regulate (i.e. domesticate) the body in monastic environments. This may very well apply also to the monasteries I have investigated, but there it seems to be a secondary explanation (Bergqvist 2013, 163ff, 272).

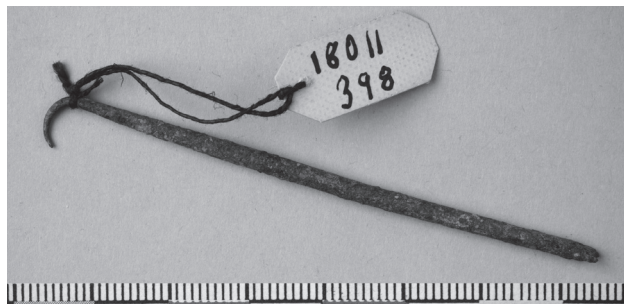


Figure 6.3. Small sharp surgical hook from Vreta (SHM18011:398a:1). Photo: Christer Åhlin, NHMS.



Figure 6.4. Probes/curettes from Alvastra (SHM21530:45 & SHM20748:5). Photo: Gabriel Hildebrand, NHMS.



Figure 6.5. Phlebotomy irons from Vreta (SHM18011:280; SHM18011:245). Photo: Christer Åhlin, NHMS.

The distinction of hygienic artefacts can be motivated by their more personal character and how they were used to enhance physical wellbeing in general, but also for preventive care of the body. In this group I have included ear scoops and tooth picks (Fig. 6.6). Combs could also be considered here, as they were also used for removing lice, but are excluded from this study as the quantity of the material would be cumbersome, while not adding much to the picture. Preventive care was certainly an important part of medical care, but I distinguish the group of hygienic artefacts from other medical gear, as they could be used by any individual without any knowledge in leech craft and without an intention to cure in mind.

The last category, the domesticating items, is made up of depilation tweezers (Fig. 6.7). The depilation tweezers could, strictly speaking, also be used for surgically or medically motivated depilation, but the archaeological data I have analyzed suggests



Figure 6.6. Ear scoops from Alvastra (SHM16811:83 & SHM16811:84 & SHM21530:47). Photo: Gabriel Hildebrand, NHMS.

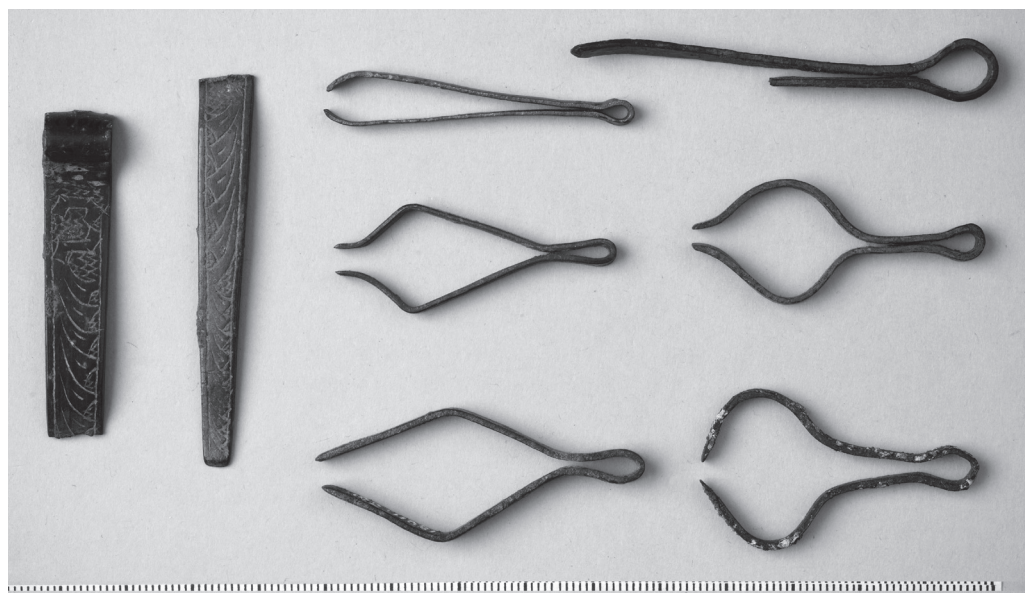


Figure 6.7. Depilation tweezers from Vreta (SHM18011:211 (2), SHM18011:398A, SHM18011:126:2, SHM18011:17, SHM18011:127:4, SHM18011:301, SHM18011:G). Photo: Christer Åhlin, NHMS.

that they were more often personal items. When it comes to their occurrence in Swedish Cistercian monasteries, they have a very clear connection to the female institutions, as depilation tweezers are abundant in the female but absent in the male institutions. In profane milieus, a cosmetic use is close at hand (Cabr  2010, 127). This should not be

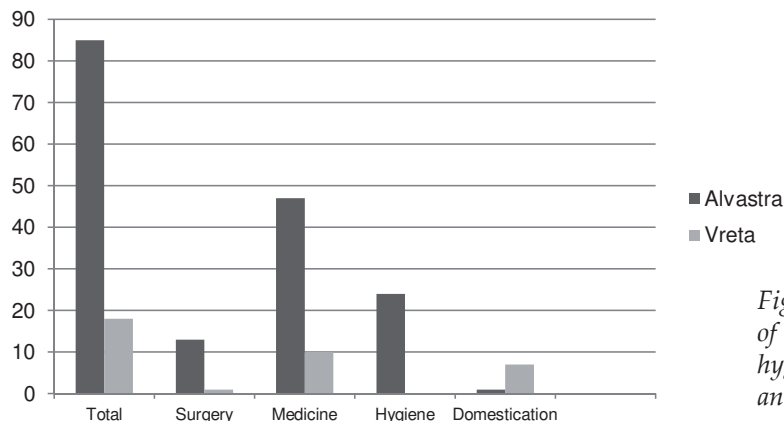


Figure 6.8. The number of leech craft and hygienic items in total and per category.

excluded in the case of religious institutions, especially considering the inherited high social status of many nuns. It is in this context also possible to compare the female habit of depilation with the male shaving of tonsures. The tonsure symbolizes humility under God but, as Cassidy-Welch has discussed, can also be seen as a monastic regulation of the body (2001, 63). Among nuns, the shaving of tonsure was not practiced. However, cutting and hiding of the cephalic hair was practiced, as female hair was a potent symbol of female beauty and attraction. For the same reason, the depilation of facial hairs might have been practiced among pious nuns as a means of domesticating the body.

As Figure 6.8 shows, differences between the male and the female institution are made apparent when the artefacts are divided into these four categories. Interestingly, the proportions between the categories are not constant, but vary among the two institutions. While the items of medicinal character constitute a large part of the total number of artefacts in both Alvastra and Vreta (a little more than 50 per cent), surgical items constitute more than twice the number of the items in Alvastra as in Vreta. Furthermore, the hygienic artefacts are completely absent from the Vreta material, while well represented in Alvastra. On the other hand, the artefacts I have classified as meant for bodily domestication are more abundant in Vreta than in Alvastra. The use of these classifications thus allows us to recognize significant differences between the two institutions when it comes to material culture used for different forms of bodily attendance.

The proportions seem to suggest that medical care in the form of distribution of medication existed at both institutions with equal accessibility. What is interesting is that specialized equipment in the form of probes, forceps and curettes is strikingly missing in Vreta, indicating that smaller wounds, boils and fistulae were not treated in as qualified a way in Vreta as in Alvastra. Surgical treatments seem to have been more common in the male institution, but from Vreta we have a very special instrument in the form of a sharp surgical hook, one of only two finds of its kind from all of medieval Sweden (Bergqvist 2013, 77ff). This suggests that the *lækir* had a more extensive practice in Alvastra than in Vreta, but also that skilled ones at least occasionally visited the female institution.

Personal hygiene – or at least special equipment for attending to it – was obviously less important among the nuns than among the monks. Ear scoops and tooth picks are

totally absent in the Vreta material. Among the brethren, on the other hand, these items were abundant, and might have been used by many inhabitants regularly. Another discernible feature is that regulation or domestication of the body by depilation seems to have been a solely female practice.

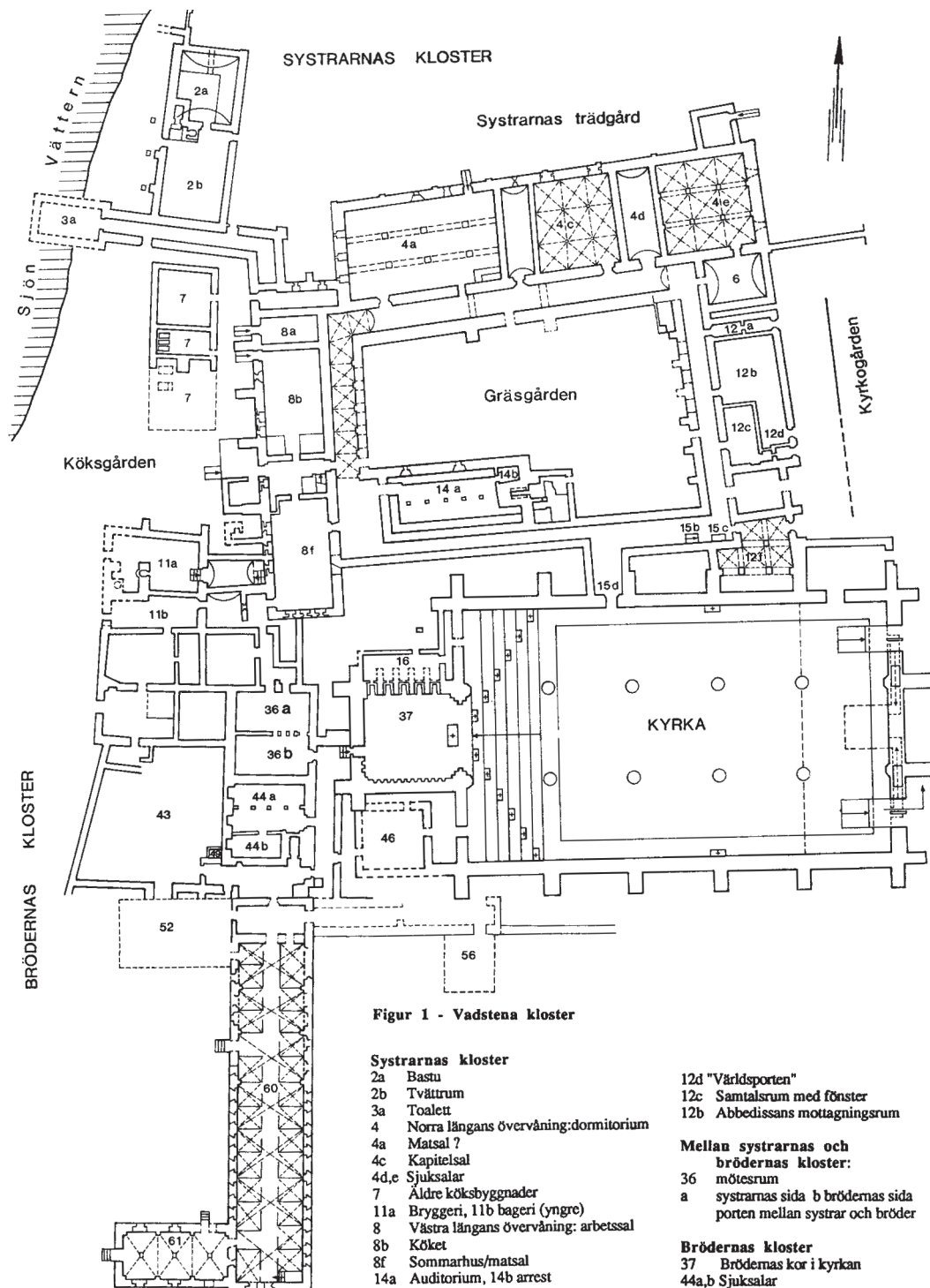
Gendered Ailments Recorded in the *Diarium Vadstenense*

I will now direct attention to the *Diarium Vadstenense*; a fascinating source which is hitherto unexplored in relation to matters of disease, illness and hygiene.

The Birgittine monastery in Vadstena was founded at the end of the fourteenth century and lasted most of the sixteenth century, although it was heavily reduced after the reformation, with only a limited number of sisters remaining. It was first and foremost a female institution, but included a separate male section, lodging a smaller number of priests for administering the Masses and certain other tasks forbidden for the sisters. There were also some lay brothers and sisters *extra claustrum*.

During the time that male brothers were also lodged there, they kept a diary in which all important occurrences in the monastery and surrounding world were noted. These could concern religious or political events, or incidents like plagues or fires, who took the vows and entered the monastery, who travelled and who visited, but a considerable part (a little more than a third) of the 1197 entries consists of notifications of the deaths of the institutional members. Sometimes the deceased was given an obituary testimonial, telling of his or her piety, and sometimes the supposed cause of death was noted. More often, however, the cause of death was omitted. While this probably to a large extent reflects the fact that the cause of death was often unknown, this gap between the number of noted deaths and the number of noted causes still leaves space for cultural values to have played a part – perhaps subconsciously – in the brethren's decisions on what was noteworthy enough to actually write down and what was not. In a similar way as Irina Metzler has suggested for the presence of cases of physical impairment in medieval stories of miracle healing (2006, s. 134), I suggest that these decisions were colored by religious-cultural notions. Interestingly, there seem to be some gendered differences or imbalances in these. I will discuss here four afflictions for which this seems to be the case, which makes them stand out in the reading of the *Diarium*. None of these can be explained by actual bio-pathological differences in how men and women are afflicted, nor by the ways of living of the men and women in the Vadstena monastery.

The first affliction is sudden dumbness, often in combination with just as sudden paralysis (DV 132; 356; 580; 651; 652; 689; 859; 968; 1001; 1037), sometimes reminiscent of a stroke. These ailments are the most commonly noted of all among the male members, and they are something that is noted only for them. There is not a single case recorded among the women. It is possible that a high frequency of strokes (which can cause partial lameness in combination with loss of speech) among the brethren was caused by excessive consumption patterns, such as those established by Barbara Harvey for Westminster Abbey (1993, 34ff), even if there are currently no studies to support that this was the case in Vadstena or at other Swedish institutions. Instead, as the loss of speech and the ability to move could endanger the afflicted men's ability to perform their main cloistral duties, perhaps it was all the more noteworthy whether this was



Figur 1 - Vadstena kloster

Systrarnas kloster

- 2a Bastu
- 2b Tvättrum
- 3a Toalett
- 4 Norra längans övervåning: dormitorium
- 4a Matsal ?
- 4c Kapitelsal
- 4d,e Sjuksalar
- 7 Äldre köksbyggnader
- 11a Bryggeri, 11b bageri (yngre)
- 8 Västra längans övervåning: arbetssal
- 8b Köket
- 8f Sommarhus/matsal
- 14a Auditorium, 14b arrest
- 15d "nådens port"
- 16 Systrarnas 5 bikttnischer "vindöga"
- 15b Trappa till systrarnas läktare i kyrkan
- 15c Skådegravarna
- 12a Läkarens port
- 12f Mottagningsrum för biskop

12d "Världsporten"

- 12c Samtalsrum med fönster
- 12b Abbedissans mottagningsrum

Mellan systrarnas och brödernas kloster:

- 36 mötesrum
- a systrarnas sida b brödernas sida
- porten mellan systrar och bröder

Brödernas kloster

- 37 Brödernas kor i kyrkan
- 44a,b Sjuksalar
- 43 Klosterträdgård med 49 "Britas källa"
- 46 Bibliotek
- 52 Matsal
- 56 Arrest
- 60 Dormitorium
- 61 Kapitelsal

prevented, or if they endured and proceeded with their work despite their afflictions. Of one brother it is for example recorded that '*postquam paralisim incurrit, perduravit in illa infirmitate usque ad mortem, nec loquelam recuperavit. Sed tamen officio non resignavit*' ('after he had become lame, he endured his infirmity until he died and did not regain his power of speech. All the same he did not resign from his office', DV 580).

The second example concerns leprosy, which is a disease mostly noted for women (DV 138:2; 294:2; 346; 937; 999). Together with pestilence, it is the most commonly stated cause of death for the female inhabitants and noted four times as often for women as for men. Some groups of medieval society believed that women were immune to leprosy (Jacquart and Thomasset 1988, 188f), but as will be discussed below, leprosy and discharge from wounds figure in several medieval texts by, for, or about pious women. Leprosy (including different diseases with related symptoms) therefore seems to have had a special connotation in relation to pious women. Perhaps this connotation has increased the attention given in the diary to afflicted sisters. Regarding one of the women in Vadstena it is said that '*Hec virgo erat et bone conversacionis; sed ad eius maius meritum in sexto anno professionis sue infecta fuit lepra, in qua finivit vitam suam in magna paciencia*' ('She was a virgin and a good convert; but as an even greater merit [emphasis mine] she was infected by leprosy in the sixth year after her inauguration, in which disease she ended her days with great patience', DV 138:2).

The third example concerns sudden and dramatic incidents, such as accidents at work, strokes or other suddenly occurring ailments in the middle of some performance of religious ritual or practical work (DV 78; 131; 228; 336; 794; 1051:2). This is something only noted to have afflicted the brothers. On a couple of occasions such a sudden ailment is explicitly said to have occurred during a brother's performance of Mass, for example '*Frater autem quidam, quem ordo tangebatur, accessit ad altare missam celebraturus; qui cum venisset ad offertorium et fratres cantaverunt Credo, tantam incurrebat debilitatem, quod ultra missam proseguere non valebat*' ('One brother, the one in turn, approached the altar to celebrate Mass. When he arrived at offertory and the brothers were chanting Credo, he became so ill that he could not complete Mass', DV 131:2). The sisters led more physically active lives than the priest brothers and were engaged in practical and heavy work which could have had consequences as serious as the male tasks. Therefore, it is noteworthy that there seems to have been a greater tendency to note sudden and dramatic changes of the states of health for the men in the middle of their activities, than for the women.

The fourth and final example, namely deadly accidents resulting from obesity, has similarities with the previous one, but has a totally different aura. It is mentioned only twice in the diary, but those passages are quite remarkable both in the described courses of events and in the way they were written. The first reads '*Nam cum surrexisset ad matutinas fratrum celcidit resupina. Et cum esset grossa mulier, viscera eius dirupta sunt; et sic post modicum tempus exspiravit.*' ('For when she had gotten out of bed by time for the brethren's Matins, she fell backwards. And because she was a fat woman, her

Figure 6.9. (opposite) Plan of Vadstena monastery (Rajamaa 1992, 70). The sisters' buildings are situated north and north-west of the church and the brethrens to the west and south-west.

intestines burst, and so she died after a short while.' DV 653). The second passage says: '*Et sumptis sacramentis in infirmitorio cecidit de sedili frangendo collum pre corporis ponderosa pinguedine statim exspirans*' ('And after she had received the sacraments, she fell off a chair in the infirmary, broke her neck because of her fat and heavy body and died immediately.' DV 977). Both cases concern sisters who are explicitly said to have died because of their obesity. This is remarkable as it could not really have been the cause in the way described. There is, moreover, no reason to believe that obesity was more common among the female inhabitants than among the males. It is interesting that we here again have only one sex represented.

What I have brought forward above is Cistercian material evidence in the form of absence of hygienic devices such as ear scoops, and wound treatment equipment, such as probes and curettes, at nunneries, while these items are very well represented at male institutions. I have also observed the tendency in the *Diarium Vadstenense* to note sudden lameness, dumbness and work-related accidents only among male monastic members. Leprosy is, on the other hand, noted chiefly for female members and obesity only for them. The notations on female obesity are phrased in terminology which, I believe, signals low esteem. The question is how these observed actual differences and tendencies in the material and written evidence should be understood and what they express.

Gendered Religious Expressions in Relation to the Body

During the Middle Ages in Europe, the construction of gender was highly influenced by antique Aristotelian and Hippocratic ideas on the balance of elements, humors, temperatures and other associated qualities. Men were generally perceived as more hot, dry, verbal and intellectual, spiritual, cultural and active. Women on the other hand were perceived as more cold, moist, emotional, physical, natural and passive. It is probable that these ideas were at least partially shared by monastic people in Sweden and that it might have affected their way of living and their religious expressions. Several scholars, especially in the late 1980s and 90s, have studied the relationship between gender and religion in the Middle Ages, and have suggested that there was a close correlation between the two.

One such relationship for females was between piety and the renunciation of food. As pointed out above, obesity in females was noted in rather condescending words in the *Diarium Vadstenense*, which gives reason to suspect influence from underlying norms. Caroline Walker Bynum has studied medieval religious women (primarily in the thirteenth–fourteenth centuries), and the role that food, or rather the renunciation of food, played in their religiosity. By studying written evidence concerning exceptionally pious (mystic) women, she found that food played a significantly more prominent role in their religious experiences and expressions than it did for their male counterparts. Being denied participation in Mass, reception of the Eucharist and the partaking in the sphere of canonical ritual performed by pious men, women sought other means of shaping their lived piety (Bynum 2007, 4). As preparation and distribution of food was generally considered to be in the domain of women, this was a sphere which

women could control and to where they could therefore direct their behavior. As food was generally accessible in the female sphere, the rejection of it became a particularly powerful and therefore preferential way for women to express holiness. While Rudolph Bell had previously recognized that self-starvation as an expression of holiness ('holy anorexia') during this period was mainly a female phenomenon (Bell 1985), Bynum in her work has focused more closely on the medieval cultural context of this phenomenon, which has strengthened this argument further.

Both Bell and Bynum have understood self-starvation as the answer of pious women to the exclusion enforced by patriarchal and hierarchal structures which precluded women from partaking in conventional means of religious expression. Returning to the *Diarium Vadstenense*, there was, as already noted, nothing to suggest that obesity was actually more common among the sisters than the brothers. Rather, the living conditions of the two groups would suggest the opposite. Perhaps, however, it was more shameful for women than for men in a religious milieu? Perhaps it was a larger contrast to the lean and undernourished ideal of a pious woman, the *holy anorectic* (cf. Bell 1985), than for men, who did not have the same focus on this bodily aspect as part of their religious identity.

Leprosy or 'kinds of leprosy' are in the *Diarium Vadstenense* almost solely recorded for female members. The attitudes towards this disease were complex and multifaceted, as shown by for example Carole Rawcliffe (2009). The endurance of this most feared of diseases was perceived to be a preeminent token of piety. It has been shown by Bynum (e.g. 1991, 133) that diseases of this kind played a special role in female religiosity, especially among mystics. As an opportunity to repent and elevate ones piety, it could sometimes be seen as a gift from God, as a 'bridal chamber', and the wounds be likened to sources of mother's milk (Bynum 1991, 131ff, 188ff). Bynum brings forward evidence of how holy women sometimes embraced the disease, in extreme cases even consuming pus and scabs from other lepers, which were perceived 'as sweet as communion'. This act was used as another means of expressing their devout piousness and thus giving disease a positive connotation (Bynum 1991, 132). Three of the four lepers mentioned in the *Diarium Vadstenense* are explicitly noted to have been very pious, or to endure their disease with great patience. This ties in well with Bynum's studies of female saints and their relationship with leprosy. It was actually a favoured disease for patient pious expression and might have played a part in individual pious profiles among the Vadstena nuns. It is explicitly emphasized in the diary how they patiently endured their trials.

The absence of the kinds of wound treatment instruments at Swedish female institutions which are to be found at the male institutions, might be understood as an aspect of this ideology. If the endurance of leprosy and other skin afflicting and wound creating ailments were welcomed as a sign of female piety and a means to increase their individual religious status, there might have been less use for specialized instruments to treat such afflictions. According to Bynum, in the late Middle Ages, 'there is clear evidence that behavior and occurrences that both we and medieval people see as 'illness' are less likely to be described as something 'to be cured' when they happen to women than when they happen to men. Women's illness was 'to be endured', not 'cured'. Patient suffering of disease or injury was a major way of gaining sanctity for females but not for males' (1987, 199). Not only wound treatment equipment, but also

surgical instruments are less common in female Cistercian material, and perhaps this relative absence of equipment in the female institutions can be explained by a different appreciation of the pious female body's need of skilled medical treatment.

A routine form of bodily attendance, which can be clearly confirmed for the male Cistercian institutions, is the practice of removing ear wax with the help of ear scoops. As no such items have been found in female institutions it seems as if they did not share this practice. Other forms of hygienic habits are, due to the sources, more difficult to elucidate. Roberta Gilchrist has, however, studied the architecture and physical allocations of religious institutions in medieval England, as well as liturgical expressions within these institutions. Arguing that material culture was actively used in forming gendered monastic landscapes, she suggests it signals that the pious female was to a greater extent peripheral, passive and corporeal (Gilchrist 1994, 66, 125, 133ff). She has shown that nunneries to a larger extent lacked sanitary facilities, such as latrines, which seem to have been normally present in male institutions, and suggests that '[p]oor sanitation may have been one means by which religious women denigrated their bodies' (Gilchrist 2000, 100).

In Swedish institutions, stone built water conduits on ground level (for fresh water supply as well as waste removal) have been archaeologically established at both Alvastra and Varnhem. Such arrangements seems to have been present also in the earliest phase of Vreta monastery (when it may have been a male institution), but not in the following periods when it was clearly a nunnery, and not at Gudhem. Gilchrist has suggested that the absence of architectural sanitary arrangements in nunneries could be interpreted as the neglect of hygiene as a part of pious women's practice. This should, as I understand it, be understood as sanitary neglect on an institutional level, as the built environment effected the whole congregation of nuns. Perhaps this pattern, observed by Gilchrist for an earlier period in England, has some validity also in medieval Swedish Cistercian architecture. However, the archaeological evidence in the form of items from Vreta versus Alvastra suggests that this form of neglect of sanitation as a part of pious women's practice was also expressed on an individual level through the default of certain aspects of personal hygiene.

The idea of the female, as first and foremost a physical being, shared within the monastic sphere (even if not by secular Swedish society), probably influenced how these women understood themselves, and therefore also influenced how they expressed their religiosity. It has been suggested that expressed female piety was more developed in the areas of life where they had a higher legitimacy than men (*i.e.* in the domains of food preparation, household maintenance, and bodily tending), namely the own body and its functions (Bynum 1991, 131ff). Disease and self-starvation, and – I would add – other forms of bodily attendance, could thus meld together in the inner experience, as a form of *imitatio Christi*.

Male piety seems to have had rather different connotations and expressions. Most striking in the evidence I draw upon, apart from the presence of the above noted traits which are absent for the nunneries, are the paragraphs on male lameness, dumbness and accidents 'at work' at Vadstena. Rosemary Radford Ruether recognizes a polarization between male and female lived piety during the Middle Ages, which she characterizes as '[m]ale scholastics and women mystics' as different models of pious expression (1998,

80). While men had access to scholarly activities and other kinds of intellectual stimuli, women were to a great extent excluded from these. Instead, a pious and ambitious woman could express herself in prophetic ways and as a mystic.

Richard Kieckhefer (1991) argues that medieval male religiosity was to a larger extent expressed through outward, objective and public behavior, often with an explicit pedagogical mission. He has also identified different forms of pious acts, such as prayer and liturgical actions, as common themes in male pious expressions. What dumbness and paralysis actually do is obstruct verbal communication and power of action. Considering the discussion above, this might have been considered especially serious for a brother as the main task of the brethren was to administer the Masses, by reading, chanting, praying and performing the rituals. In line with this argument, the attention paid to dramatic accidents striking the brothers with muteness and lameness or even death in the middle of their active deeds, can be understood as a concern for the interference it meant in their male role as the intellectual and active gender.

Conclusion

The evidence discussed in this article is collected from a number of Swedish late medieval (mainly late thirteenth to early sixteenth centuries) monasteries and nunneries. The evidence reveals some imbalances in need of explanation. I suggest that these imbalances be interpreted as expressions of gendered attitudes to the body and to disease, and also to the ideal roles of men and women in a strict religious milieu. I have given examples of how gendered ideas and ideals are reflected in the attention given to physical ailments and causes of death among the members of the double monastery of Vadstena in late medieval Sweden. I have also, by looking at the material culture from Cistercian institutions, suggested that these ideas and ideals affected the lived reality of the men and women who inhabited these institutions in very concrete ways.

The evidence available to us is fragmented and may seem disparate. It is, however, collected from a group of institutions within a relatively limited area of southern Sweden. Although belonging to different orders (the Cistercian order and the Order of the Most Holy Saviour, or the Brigittines), it is known that Saint Brigitta repeatedly visited Alvastra monastery. It would be surprising if there were not also personal connections to the nunnery of Vreta, as this was in close contact with Alvastra. Most of the material is relatively contemporary, although, particularly when it comes to the material culture, it is chronologically spread over a couple of centuries. Nevertheless, the sources are rich for Swedish standards for this period and thus valuable to us, and they possess an up until now unexploited potential for the questions posed here.

According to several scholars on late medieval religiosity, as noted above, male pious religiosity was primarily expressed by actively taking part in Mass; by praying, chanting, administering and receiving the communion and performing various other canonical rituals, which was notably the brethren's *raison d'être* in Vadstena. This is what has formerly been perceived as the normative means of religious expression, and although nuns too could participate in intellectual literate activities (e.g. Lee 2001), much of this was actually denied to women and was instead performed within a specifically male

domain. In all these tasks the male priests – the brethren – played the verbal and acting part within a highly regulated, intellectualized and cultural sphere. Not being able to partake in this due to bodily ailments may therefore have been perceived as especially grave among the male monastic inhabitants, and therefore particularly noteworthy and consequently written down in the *Diarium Vadstenense*.

As for the ‘other gender’, both the material culture – or rather the absence of it – in Vreta and Gudhem, and the records in the diary of Vadstena, can be interpreted in terms of expressions of female pious religiosity: the pious embodiment of disease, perhaps especially leprosy and other skin afflicting diseases and smaller wounds, and also the forsaking of personal hygiene, being such expressions. The renouncement of food was an equally important component of female religious asceticism. Self-starvation, what has sometimes been called *holy anorexia*, was thus another means of expressing piousness, practiced more by women than men. Being overweight may therefore have been perceived as especially shameful and pathetic in a piously religious woman – more so than in a man. Holy men also used physical asceticism as part of their religious expression, but several researchers, as referred to above, argue that physical expressions of piety and physical asceticism was much more common among pious women, which is explained by the more physical comprehension of the female being.

The relative abundance of equipment at Alvastra and Varnhem for bodily attendance by means of surgery, medicine and wound treatment, as well as personal hygiene, and the relative scarcity or even total absence of it at Vreta and Gudhem suggests that neglect of physical care was not a prominent feature for pious men in late medieval Sweden. Rather, a well tended body may have comported well with the idea of men as being more cultured and civilized. The same sources suggest that it might, on the other hand, have been important among pious women. Bodily domestication was important also among the latter group.

In the introduction to this article, I posed a question concerning the relationship between disease and the wish for a cure, and if the latter always follows from the former. Above, I have tried to show that this is not necessarily the case. Rather, disease can be and was being used as a statement, as part of self image and as a means of expression among pious women. The medieval ideas of gendered religiosity influenced what was during that time perceived as an actual disease – or as a noteworthy disease and a disease in need of curing – in the strict religious societies that the Cistercian and Brigittine monastic institutions constituted. With the support of later medieval archaeological and written material from a number of Swedish institutions, I accordingly suggest that it therefore also affected what kinds of surgical, medical and hygienic treatments were expected and actually provided – or not expected nor provided – among these pious men and women.

The study presented here does not have any precedents in the geographic area in question. It is part of a larger archaeological PhD project in which I explore both profane and monastic materials connected to leech craft in medieval and renaissance Sweden, and thus am able to evaluate the evidence presented here in a wider perspective, which adds further nuances to the matter (Bergqvist 2013). As this is to a large extent basic research, for the future it would be valuable if more intensified and particular studies could be done on Swedish and broader Nordic materials, both archaeological

and historical, in order to better understand the local practiced religiosity and pious expressions, how it related to the surrounding Swedish/Nordic society and to European circumstances, where Christendom was adopted much earlier. For example, the *Diarium Vadstenense*, together with other written data from the Brigittine institutions, has more to say on the matter. It would also be very interesting to compare archaeological evidence (where available) in a larger European scale, from a number of monastic institutions so as to be able to compare the different monastic orders.

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Abbreviations

DV – *Diarium Vadstenense*

NHMS – *National Historical Museum of Sweden*

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DV, see *Vadstenadiariet*.

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7. The Rattlesnake and the Otter: Anthropology, Gender, and Contraception among the Niitsítapi (Blackfoot) in the 1930s

Kristin Burnett

Introduction

The Niitsítapi, or Blackfoot Nation, the collective name of three Indigenous tribes located in present-day southern Alberta (Canada) and Montana (United States), used traditional contraceptive practices well into the twentieth century. Evidence of this persistence comes from two sources: Indigenous oral histories and the unpublished field notes of anthropologists who worked among the Niitsítapi during the 1930s. What these unpublished anthropological accounts of the reproductive practices of the Niitsítapi can reveal about European-American society during the 1930s, Indigenous contraceptive practices, and differing cultural perceptions about birth control are the focus of this chapter. That anthropologists, well-trained and regarded in their field, failed to publish the descriptions they collected of Niitsítapi contraceptive practices is significant and worthy of further examination especially during a period when issues of birth control and abortion were centre stage in Canadian and American politics. Most importantly, examining birth control practices makes the healing work and knowledge of Indigenous women especially visible in a documentary record that has privileged the more public and masculine elements of Niitsítapi culture.

In the late 1930s the anthropologist Ruth Benedict organized a field school among the Niitsítapi in southern Alberta. She enlisted the following graduate students to work at the school: Jane Richardson Hanks, Lucien Hanks, Esther Goldfrank, Oscar Lewis, and Claude Schaeffer. Each of them spent several summers working on the project. These students were part of the ethnographic stampede of the late nineteenth and early twentieth centuries, rushing to witness and record what they believed were 'traditional' Indigenous cultures before they disappeared forever. However, in the process of looking for the extraordinary and unique these anthropologists recorded a range of social and cultural practices central to the Niitsítapi people's daily lives. Significantly though, only Esther Goldfrank's and Claude Schaeffer's unpublished field notes contain vivid descriptions, albeit brief, of the Niitsítapi's contraceptive practices. Indeed, contemporary anthropologists who otherwise mined Indigenous cultures for evidence of 'traditional' culture largely overlooked the Niitsítapi's complex system of beliefs and practices about contraception.

During the late nineteenth and early twentieth centuries anthropologists observing and recording Indigenous culture believed they were performing a service by chronicling what they considered were the last vestiges of a vanishing race. Thus, anthropologists tended to focus on those cultural practices that seemed to be remnants of a 'far gone' past, and not those customs that were in their view part of the present and future. Scholars have recently identified this practice as salvage anthropology. Anthropologist Shirin Azizeh Khammohamadi (2011) defines salvage anthropology as the 'salvage of cultural materials under threat of colonial incursion and loss, while giving expression to [one's own] anxieties over shifting cultural boundaries.' These observers accepted the 'fact' that Indigenous people and their cultures would be subsumed by the dominant European-American society and failed to question how this was happening. Nor did the anthropologists conceive of themselves as complicit in this destructive process. Additionally, focusing on the more masculine, visible, and spectacular rituals of Plains peoples' curative regimes, while discounting a broad range of women's healing skills, anthropologists ignored the everyday work and knowledge of Indigenous women and cast a picture of Indigenous medicine that ignored the therapeutic systems of Indigenous peoples that were codified and transmitted from generation to generation (Burnett 2010, 3–5). Indeed, this epistemological violence was part of the broader colonial re-imagining of Indigenous peoples in North America that made them into a 'present absence' which 'reinforce[d] at every turn the conviction that Native peoples [were] indeed vanishing and the conquest of Native lands [was] justified' (Smith 2005, 9). Accordingly then, what need did a disappearing people have for contraception?

Although deeply embedded in the epistemological process of erasing Indigenous knowledge, anthropologists claimed they were objective bystanders recording neutral descriptions of Indigenous culture (Fabian 2001). This could not have been further from the truth. These observers were not impartial onlookers, what they witnessed, wrote down, and later published was shaped and informed by their profession, gender, race, and ethnicity. The anthropologists' gaze recorded a vision of 'Indians' that often revealed more about European-Americans than it did about Indigenous peoples (ibid.). Nevertheless, a careful reading of the unpublished texts of Esther Goldfrank and Claude Schaeffer offers a brief glimpse into both the contraceptive practices of the Niitsítapi people, and the anthropologists' silences around these practices. In so doing, it also opens a window onto how European-Americans viewed contraception more generally.

Canada and the United States criminalized contraception and the distribution of all birth control information during the nineteenth century and, with some exceptions, this remained unchanged until the late 1960s and early 1970s respectively. As a result, early historical works about contraception focus on tracing women's struggles, largely from a white, middle-class perspective, to have the right to 'decide if, when, and how many' children they wanted to have (Berman 2011, 433–35). The emergence of contraceptives like the birth control pill and the struggle to legalize abortion feature prominently in this whiggish narrative of women's increasing control over their bodies (Gordon 1976; McLaren 1997; Reagan 1997).

Intimately connected to this teleological story of reproductive choice is the belief in the ability of biomedicine and technology to grant women the ability to choose when

and how they reproduce. The emergence of antiracism, post-colonialism, and disability studies in the last several decades (Roberts 1998; Caron 2008; Kluchin 2009; Reagan 2009) complicates this tale by suggesting that reproductive rights are not just the 'unyok[ing of] sexual intercourse from procreation' but rather the 'right to the social, economic, political, legal, and cultural circumstances that foster voluntary reproductive choices' (Berman 2011; 433) for women and their communities. In women's pursuit of safe and effective birth control, however, alternative cultural understandings of birth control methods among marginalized groups such as Indigenous peoples have not been well studied. Historian Angus McLaren criticizes the failure of scholars to examine birth control practices that do not conform to biomedical definitions of contraception (McLaren 1984, 5). For instance, historians have almost entirely overlooked the history of contraception practices in Niitsítapi communities especially during the period under examination. Childbirth in Indigenous communities was and is still a topic of interest, especially in the recent decades, as midwives and their supporters search for a respectable past and for a template of a less medicalised, and female-centred birth culture (MacDonald 2004). However, a corresponding interest in Indigenous contraceptive practices has not emerged. Historians have thus largely disregarded the fact that Indigenous people employed their own means of contraception which appeared effective, reliable and appropriate within their cultural context.

This chapter seeks to illuminate a number of noteworthy and intersecting themes around reproduction and colonialism that played out in North America during the late nineteenth and early twentieth centuries. In order to do so, the chapter will first outline who the Niitsítapi are as well as the historical sexual division of labour and healing roles in their communities. Following the entry of anthropologists into Niitsítapi communities in the 1930s and considering a sketch of the contraceptive practices these observers recorded will highlight the different cultural and social understandings of contraception between the Niitsítapi and European-Americans. Furthermore the chapter queries the reasons for the failure of anthropologists to publish the information they recorded, which sheds light on European-American society's attitudes towards race, Indigenous peoples, and birth control in the late nineteenth and early twentieth centuries. Finally, the chapter concludes with a brief consideration of the post-WWII period to demonstrate the persistence of the Niitsítapi's contraceptive practices, in spite of the dramatic changes that occurred in their communities throughout the twentieth century.

The Niitsítapi

The Niitsítapi (Blackfoot Nation), meaning original people, is comprised of three tribes: the Siksika (Blackfoot), the Kainai (Blood), and the Piikani (Peigan). The Piikani are further divided into the North and South Peigan tribes. Currently, the Siksika, the Kainai, and the North Peigan live in southern Alberta while the South Peigan live in Montana and are referred to as the Blackfeet. These current divisions reflect the drawing of national boundaries in the nineteenth century and not internal tribal divisions (McCrary 2006). From the late nineteenth to the early twentieth centuries

the lives and communities of Indigenous people in the Canadian West were changing profoundly. The 1870s and 1880s witnessed the signing of the numbered treaties, the establishment and confinement of Indigenous peoples to reserves, the last buffalo hunt, the growth of white settlement, and the consolidation of the colonial state in western Canada. Such changes took their toll on southern Alberta's Indigenous communities; for example, the reserve system made it increasingly difficult to pursue hunting and gathering activities and populations declined dramatically from diseases of poverty and starvation (Carter 1999, 95–96). This distress was exacerbated by the unsympathetic treatment of Indigenous peoples at the hands of the federal government, which failed to fulfil its treaty obligations. Throughout this period however, Indigenous women continued to employ their expertise in healing and in local plant use to ensure the well-being of their communities (Carter 2002). These women adapted to changing health situations as best they could adopting new treatments when necessary, and relying on established curative and caregiving practices that continued to be effective and relevant to their communities (Burnett 2010).

The Niitsítapi, like many contemporary North American societies, practised a sexual division of labour which shaped women's use of space (Medicine 1983). Women carried out most of their work in the camp, where they were responsible for setting up and looking after the lodge (which the women owned), as well as for raising children, tanning hides, making clothes and tipi covers, collecting roots and herbs, and preparing food (Blackfoot Gallery Committee 2001, 26). Outside the camp, women's responsibilities included gathering edible and medicinal plants. In the early spring, women and children gathered wild plant foods and in the late spring women dug bitterroot (Ewers 1958, 86; McMillan 1995, 44). In July, they dug wild prairie turnips and camass bulbs near the mountains, midsummer saw women and children collecting savis berries (also known as sarvis berries, service berries, june berries, and saskatoon berries) and in October they gathered chokecherries (Ewers 1958, 86). These harvesting activities ensured that the Niitsítapi had a mixed diet; they also cushioned communities against times of scarcity (Carter 2002). Young girls and women acquired their botanical knowledge from female Elders, often serving long apprenticeships.

Besides their numerous gathering activities, women hunted and snared small game, fished, and helped their male counterparts with the buffalo hunt (Ewers 1958, 84). While the buffalo were extremely important to the Niitsítapi, (Carter 1999, 25) they were part of a broader economy. Given the '*unpredictable alternation of abundance and scarcity*' (Isenberg 2000, 75–80) that was characteristic of a reliance on buffalo, survival and prosperity in this region meant locating and drawing from a wide variety of animal and plant resources, which in turn meant that women's knowledge of the local environment was vital. Effective subsistence strategies, however, were not always consistent with a strict sexual division of labour, and there was some flexibility. Women's and men's activities were frequently determined by need and practicality. For example gathering activities were often performed communally involving members of both sexes, (Carter 2002, 138), with general knowledge about edible and medicinal plants being shared for the benefit of everyone. Plant gathering, much like a successful buffalo hunt, required the participation of the entire band. The well-being of the community was a collective endeavour in which all members participated.

In Niitsítapi communities, individuals, entire groups, societies, or even the whole tribe conducted healing rituals and ceremonies. The spiritual and religious practices of the Niitsítapi were gendered, with women playing important but complementary roles to the more public and performative activities of men. While the spiritual and communal well-being of communities has been well studied less attention has been paid to how Niitsítapi people addressed more mundane, day-to-day health concerns. The scholarly literature typically focuses on individual or collective responses to illness and ill health and says little about routine practices (see: Grygier 1997; Kelm 1999; Lux 2001).

Women's knowledge of medicinal plants was a particularly important part of Indigenous peoples' responses to new and existing health problems. Botanical cures were sometimes received in dreams, but more often than not women acquired their knowledge of plants from an apprenticeship to an older woman in the community. Healers who used plants needed to know their seasonal availability and how to harvest, prepare, and administer them as medicine. Considerable expertise was required to use plant remedies properly. As a result, apprenticeships were long, prestigious, and often expensive. In the decades following the Second World War, ethnobotanist Joan Scott-Brown (1977) found that Indigenous women who wanted to learn about plants from their female Elders had to purchase the knowledge. One woman interviewed by Scott-Brown expressed concern that because the learning process took a number of years and was expensive, her grandmother might pass away before she could afford to complete her education (Scott-Brown 1977, 148–54). Turning our attention to these kinds of healing practices brings women's work to the fore.

Indigenous healers adapted traditional remedies to treat the symptoms of new afflictions. When poor rations (including white bread and bad meat) caused digestive problems, Niitsítapi women brewed a variety of herbal drinks to alleviate abdominal distress. Likewise, people with a tubercular cough were given infusions of yellow berries or tea made from willow. Willow bark, which contains salicin, the active ingredient in aspirin, helped soothe the patient (Hellsen and Gadd 1974, 74). Much of Indigenous women's day-to-day healing involved family illnesses, accidents, and private bodily functions. Most of the work addressing these issues took place in private space, outside the gaze of male non-Indigenous observers; as a consequence, it usually went unobserved. Because this kind of domestic health care was 'normal' – that is, nothing out of the ordinary to Indigenous *or* non-Indigenous people – it was often perceived as not worth recording.

When Esther Goldfrank and Claude Schaeffer performed fieldwork among the Niitsítapi in the 1930s, most anthropologists, particularly those who were university educated, were middle-class white men who had trained under either Franz Boas or one of his students. Even with the presence of well-known and highly influential individuals like Margaret Mead and Ruth Benedict, women remained underrepresented in the discipline, in academic departments, and among tenured faculty more generally (Di Leonardo 1991, 5). The published works of anthropologists reflected the masculine character of the profession. Before the 1970s it was not unusual for anthropologists to overlook or normalize sexual differences (*ibid.*). Indeed, 'pre-feminist anthropology' often represented a 'largely male universe;' (Di Leonardo 1991, 6) a universe which in

some ways is only now being re-examined. Carefully re-evaluating the field notes of anthropologists and the process of knowledge formation through the intersection of gender, race, and class (Collins 1990, 225) allows us to see more clearly those cultural practices that were effective and relevant to the Niitsítapi but were overlooked in favour of the more spectacular and public medicine men, warriors, and buffalo hunters. According to Sandra Peacock (1992), the invisibility of Indigenous plant use, and thus a great deal of the everyday work and knowledge of Indigenous women, was a consequence of anthropologists' overreliance on male informants and the overwhelming presence of animal materials in the archaeological record. It is also quite possible that the anthropologists noted the Niitsítapi's contraceptive practices in their field notes because they saw them as quaint identifiers that confirmed the Niitsítapi's supposed 'primitiveness' (Briggs and Bauman 1999).

Contraception Practices among the Niitsítapi

It is noteworthy that the one facet of Indigenous women's therapeutic practices that the Department of Indian Affairs (DIA) and its medical and educational institutions did not try to take control of or eradicate during this period was contraception (Burnett 2010, 153–68). In every other circumstance that was deemed to be of moral and social concern, Indigenous women came under the surveillance and criticism of the DIA and various missionary organizations, but not in regards to the employment of reproductive practices (ibid.). Perhaps this omission was a consequence of the popularly held belief in the late nineteenth and early twentieth centuries that Indigenous people were a vanishing race – a perception that was only strengthened by the DIA's own reports which provided statistical evidence of poor health. Or perhaps at the time the real concern was who was reproducing? In other words, contraception among Indigenous people would only have become a source of concern if middle-class European-Canadian women had begun to follow their lead and draw on the contraceptive knowledge of Indigenous women. Thus, when the anthropologists entered Niitsítapi communities in the late 1930s they did so within a particularly charged social and cultural environment.

The unpublished field notes of the anthropologists who studied the Niitsítapi during the 1930s contain brief glimpses of contraceptive practices. Esther Goldfrank was told by one of her informants, Violet, that a woman who no longer wanted to have children would visit a medicine woman who would 'tie her up' (GA: Goldfrank, M243, field notes). Children, according to Violet, came from the power of the snake. Thus a medicine woman would prevent conception by tying a snakeskin around the woman's waist (ibid.). Besides this, medicine women would often counsel menstruating women to paint their stomachs with yellow paint as a preventative measure (ibid.).

Claude Schaeffer, who worked in southern Alberta during the 1930s with Goldfrank, recorded a wealth of material about Niitsítapi birth control practices but never published it. Schaeffer was the only man among this group of graduate students in the 1930s to record evidence of contraceptive practices among the Niitsítapi. He interviewed Mrs. Victor Chief Coward and recorded that after having three children, she sought out Mrs. Mountain Sheep Woman to prevent further pregnancies. Mrs. Mountain Sheep, whose

power to prevent conception came from the rattlesnake and the otter, (GA: Schaeffer, M1100/137, field notes) instructed Mrs Victory Chief Coward to bathe in a creek, stand over a smudge, and paint her face with yellow earth paint during the first new moon every month (i.e., the time of ovulation) (ibid.). Smudging is a cleansing ceremony where an individual burns sweetgrass (sometimes sage or cedar) and using their hands brushes or rubs the smoke over their body. She followed these instructions for eighteen months before she stopped, 'knowing [there was] no chance for further pregnancies' (ibid.). Additionally, the medicine woman gave Mrs. Victory Chief Coward a bracelet made of otter skin with a figure of a snake drawn on the inside to wear during the new moon (ibid.). Schaeffer also interviewed Jappy Takes Gun On Top, the only man he encountered who practised birth control medicine. Jappy was not interviewed by Goldfrank. Jappy's power to prevent conception was derived from the snake in the form of a beaded necklace (ibid.). Jappy also helped women who miscarried, but what form that help took was is not indicated in the field notes.

The prescriptions outlined by Violet, Mrs. Mountain Sheep Woman, and Jappy Takes Gun On Top were similar in terms of contraceptive practices: every month during the full moon, women were to bathe in a creek, stand over a smudge of sweetgrass, paint their faces or stomachs yellow, and wear a token (possibly made of otter skin) with the symbol of a snake or butterfly inscribed on it; also, they were never to lend an article of clothing to another person. If these interdictions were followed, pregnancy could be prevented. Schaeffer made notes about a woman who failed to follow the instructions given to her. Mrs. Phillip Arrowtop, after an extremely difficult delivery of twins, had approached Mrs. Victor Chief Coward (GA: Schaeffer, M1100/137, field notes) who instructed her to paint her face and smudge her shawl and warned her never to lend an article of personal clothing to anyone. Mrs. Phillip Arrowtop broke these injunctions and as a result had two more children. Mrs. Victor Chief Coward treated her again, and this time she did not transgress the prohibitions. She did not conceive again (ibid.).

These examples, though limited, point to a shared belief in the efficacy of spiritual methods of contraception among the Niitsítapi; Indigenous people relied on them because they worked. McLaren criticizes scholars for failing to discuss the ability of the spiritual to influence fertility. Instead, historians have regarded such methods as evidence that a culture does not possess contraceptive knowledge (McLaren 1984, 5). This ignores the psychological impact these methods had and have on people. Birth control does not necessarily apply solely to the biological process of conception (the sperm meeting the egg); it can refer to a whole range of methods. Schaeffer, for example, noted that the Niitsítapi used late weaning as a means of regulating and spacing births. Old Lady Bull Calf told him that 'a mother would instruct her married daughter to let [her] body nurse until [the baby] stops of its own accord' (GA: Schaeffer, M1100/137, field notes). According to her, a woman should 'nurse [her] baby as long as she desires, whenever the child wants another sibling she will cease' (ibid.). Western science now acknowledges that nursing babies reduce a woman's fertility (Short *et al.* 1991) and historians know that early-modern Europeans too used this method of birth control (McLaren 1983, 11–13).

Years later as part of a community project to record the knowledge of Niitsítapi Elders before it was lost, Beverly Hungry Wolf related a story told to her by her grandmothers regarding the spiritual powers that helped prevent childbirth:

The ones who had these powers would make up symbols of snakes or butterflies, which were considered powerful in childbirth. These were given to women who wanted no children. They had to wear them all the time, next to their bodies. For instance, snakes were made from buckskin, stuffed, and worn like a belt. The stuffings were made of special materials, and the snake bodies were specially covered with beadwork and sacred paints. Often the women were instructed to stand over a smudge of special incense, so that the smoke could rise up to their bodies. They had to do this every night for as long as they wanted no more children

(Hungry Wolf 1980, 203)

The use of visible markers to indicate a desire to limit fertility suggests that the onus or expectation for birth control did not fall solely on the shoulders of women; those markers informed *both* sexes. Perhaps because birth control practices were relatively common knowledge in the community, there was a sense of shared responsibility among female and male sexual partners. In a hunting and gathering community where mobility was of paramount importance and resources were limited, responsibility for limiting the size of the community was shared by all and essential to societal well-being. This lies in stark contrast to Anglo-American cultures, which firmly place the onus on the individual couple, and more often than not, on just the woman (Gordon 1976, 407–09). Indeed, the discourses of the birth control movement, eugenics, and scientific motherhood have all reinforced the notion that women are doubly responsible for both conception and contraception. While women remain ‘*in charge*’ of these processes they have not necessarily been empowered by them. Women can obtain birth control in clinics and pharmacies but the professionalisation of the birth control movement has ensured that contraceptive knowledge lies under the purview of a select few (Gordon 1976, 252–56). In contrast, in Niitsitapi communities, although there were experts who counselled women about controlling fertility, the knowledge was diffuse.

Spiritual, ceremonial, and ritualistic forms of birth control were not the only methods practised by the Niitsitapi. In the 1930s, Goldfrank’s informant Hilda told her:

Women take medicine to keep from having children. Many get it from a medicine woman. She knew of one woman who, when her period did not come, took a strong drink of pepper tea so as not to have kids – knows of no other kind of abortion. Women will go to a medicine woman for a brew when they are pregnant

(GA: Goldfrank, M243, field notes)

An informant provided Schaeffer with evidence that women used certain types of roots for abortion. This person also told him that abortifacients (substances that induce abortion) were considered a bad thing and equivalent to murder and that such practitioners were not highly regarded (*ibid.*). Schaeffer recorded only two women as knowing how to induce miscarriages in this way: Mrs. Home Gun and Mrs. Chief Coward. A woman named Mrs. Pete Home Gun gave this information to Schaeffer and she made it clear that she had refused any aid offered by these women (*ibid.*). Given that abortion was generally illegal or unobtainable in Canada until 1988 and in the United States until 1974, the evidence provided by Schaeffer’s informants about such practices was mediated by contemporary debates surrounding abortion and birth control. It is also quite possible that these women were graduates of the residential school system

and their testimony reflected the worldviews of Christian churches and not their own. Indeed, Mrs. Pete Home Gun's awareness of these services suggests that abortifacients may have been widely used.

Goldfrank and Schaeffer's unpublished field notes are unusual for their accounts of Niitsítapi's contraceptive practices. That Jane Richardson Hanks, the only other woman who participated in the field school, did not record such customs may suggest that gender was not the principal factor in determining whether such material was recorded. However, it is possible that Lucien Hanks, Richardson's research partner and husband, affected her access to and interest in such information. Their fieldwork and subsequent publications on the Niitsítapi were all collaborative (Hanks and Richardson 1950). Nevertheless, the picture is more complicated. Schaeffer is an unusual figure: given his gender one might assume a lack of interest on the topic of contraception or access to potential informants, yet Schaeffer took extensive notes on contraception, and interestingly, spoke to the only male informant regarding birth control practices. Perhaps, in this last instance Schaeffer's gender gave him access to information that Goldfrank's did not. Schaeffer was also one of the first professional anthropologists to write about two-spirited people among Indigenous groups. Indeed, in a career that witnessed few publications, his 1965 article 'The Kutenai Female Berdache: Courier, Guide, Prophetess, and Warrior' stands out, and suggests Schaeffer was inclined to look beyond those areas of inquiry considered conventional within the heteronormative discipline of anthropology.

A Window onto European-American Society: Niitsítapi Contraceptive Practices

The anthropologists' omission in their published works of contraceptive practices in Niitsítapi communities specifically, and European-American society more generally, can be located at the intersection of debates taking place around birth control that were deeply rooted in contemporary anxieties about immigration, 'race suicide,' and gendered cultural understandings about responsibility for birth control. Anti-immigration rhetoric reached its zenith during the interwar period fuelled by economic crises and growing nativist movements. The retreat of Canada and the United States into isolationism and fears of the non-white racialized 'other' produced legislation such as the 1923 Chinese Exclusion Act (which banned the entry of all but a select few Chinese people) by the former and the 1924 National Origins Act (which restricted immigration based on countries of origin) by the latter. In the 1930s Canada shut its doors to everyone except for white Americans, British subjects, and agriculturalists (Kelley and Trebilcock 2010, 218).

Increasing numbers of non-Anglo Saxon immigrants and falling birth rates among middle-class Anglo Saxon women during this period also lent credence to fears of racial degeneration and 'race suicide.' Doctors, social reformers, and politicians undertook various formal and informal measures to try and limit the ability of 'unfit' groups to reproduce (Grekul *et al.* 2004, 358–59). Social reformers lobbied for the criminalisation of abortion and birth control under Subsection 179c of the 1892 Criminal Code, making the dissemination or procurement of such indictable offences (Valverde 1992, 16–17).

In this manner the state attempted to control who could and could not reproduce. The rise of eugenics was intimately connected to anti-birth control and abortion legislation which reflected the medicalisation of social problems and the belief that a better 'race' could be ensured through better breeding and childrearing practices (Comacchio 1993, Baillargeon 2004, Schoen 2005). Thus, birth control was not about women gaining control over their own bodies and the right to voluntary reproduction but rather about ensuring only certain women reproduced. In the United States almost thirty states passed eugenicist laws during the early twentieth century and chose to perform sterilisations on 'undesirable' populations (Reilly 1991; Black 2008). In Canada, Alberta and British Columbia passed sterilization acts in 1928 and 1933 respectively (Grekul *et al.* 2004, 363). In both countries the state targeted Indigenous people disproportionately for sterilization (Lawrence 2000, 400–19).

The Niitsítapi and Contraception after World War II

There is evidence to suggest that the contraceptive knowledge recorded by anthropologists in the late 1930s persisted into the post-WWII period. In 1969, as part of an oral history project Niitsítapi Elder, George First Rider revealed that a woman who did not want to get pregnant could drink a combination of three herbs: cut-leaf anemone, crooked stem, and wild liquorice (FNUC: IHFP, IH AA079, First Rider). Similarly, several years later when ethnobotanists John Hellson and Morgan Gadd performed fieldwork with Niitsítapi Elders regarding plant use, they learned that knowledge about traditional contraceptive practices had persisted in the community and was still being applied. Hellson and Gadd noted that the Niitsítapi practised two methods of birth control in particular. One involved a special ceremonial bundle, which, according to Hellson and Gadd, was the property of a specific practitioner whose services could be purchased. The second method involved the drinking of a herbal mixture containing abortifacients. This was, notably, different from the bundle in that it was a contraceptive technique a woman could employ independently (Hellsen and Gadd 1974, 57).

Hellsen and Gadd's informants recounted information consistent with that related by Schaeffer and Goldfrank in the 1930s. Each of them offered evidence regarding the objects and materials that prevented conception. These items were otter skin wristlets with the design of a snake, yellow ochre, and some plant material (Hellsen and Gadd 1974, 57). All items that Goldfrank's and Schaeffer's informants had described decades earlier. However, unlike Goldfrank and Schaeffer, Hellsen and Gadd sought out more detailed information regarding which plants were used, how they were prepared, and for what purposes. For instance, Hellsen and Gadd's informants indicated that the plant materials were the flowers and leaves of the new birch sucker (*Betula occidentalis*), which were ingested if the bundle failed to prevent conception. They also identified two other plants as abortifacients: *Anemone multifida*, 'crooked stem,' and *Draba incerta* (Hellsen and Gadd 1974, 58). These researchers' field notes in conjunction with oral histories and ethnobotanical studies reveal that Indigenous people relied on both spiritual methods and medicinal plants to prevent conception and continued to do so long before and well after anthropologists arrived in the 1930s.

Conclusion

A careful reading of the unpublished field notes of the anthropologists who performed fieldwork among the Niitsítapi in the 1930s reveals that they continued to draw on tried and trusted Indigenous contraceptive practices and beliefs. The failure of earlier anthropologists to reference such practices may have been partly a function of their gender. Without the presence of women it was likely nearly impossible to gain access to certain sites of activity (the exception being the informant of anthropologist Clark Wissler, David Duvall, whose mother was Niitsítapi). It is also quite possible that these earlier male observers did not consider methods of birth control noteworthy. The presence of female anthropologists, on the other hand, during the late 1930s provided a different perspective and gave observers access to sources and potentially gendered sites of information previously invisible to anthropologists. What is puzzling is the fact that anthropologists, having learned about the birth control practices of Plains people in the 1930s, chose not to publish any of this information. Perhaps they were worried about the legal ramifications of disseminating information about birth control during the 1920s and 30s, either for themselves or for their subjects. Whatever the reason may be, unfortunately, contemporary academics have in many ways perpetuated this omission.

The process of erasing Indigenous knowledge and traditions is intimately linked to the larger colonial project in North America. Cultures without knowledge and traditions do not have a past, present, or future; thus, the erasure of Indigenous peoples' contraceptive practices is part and parcel of European-American efforts to appear natural and neutral in the North American landscape. Currently, there is a revitalized and powerful movement within Indigenous communities to reclaim and assert Indigenous birth cultures as one means of regaining control over their bodies and cultures. However, thus far, contraceptive practices have not been identified as part of this movement. Perhaps in part this is a consequence of decades of state sponsored sterilisation programs designed to ensure that Indigenous people did not reproduce; or maybe this neglect represents an unconscious adoption of western attitudes towards birth control and western medicine (Lavell-Harvard and Lavell 2006). Whatever the case may be, the as yet partial evidence is undeniable: the Niitsítapi had a highly evolved set of contraceptive practices, ranging from spiritual methods learned in dreams to the employment of visual signifiers to medical methods like the potation of abortifacients – the Niitsítapi equivalent to 'the morning after pill.' Moreover, these methods contradict popular and scholarly assumptions about Aboriginal peoples' supposed ignorance of medical practices, and that Aboriginal traditions and cultures inevitably gave way to western paradigms. Instead it is very clear that Niitsítapi contraceptive practices persisted well into the mid to late twentieth century and likely beyond, and examining such practices helps make visible the importance of Indigenous women's work in ensuring the well-being of their communities.

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8. Re-covering the Hiroshima Maidens

Amanda Jane Graham

Is trauma the encounter with death, or the ongoing experience of having survived it?

Cathy Caruth (1996, 7)

From the ashes of the atom bomb arose a post-war discourse of recovery and reconciliation. No longer a threat, Japan and its citizens 'benefited' from American patriotic altruism, albeit germinated in a modern colonial culture laced with guilt. The innocent and docile Oriental Other replaced her kamikaze brother in the American national imagination, but in some instances her exotic appeal was tainted. The traumatic event, unspeakable in two languages, marked her body. The question that arose from equal parts compassion and disgust, from Americans and Japanese alike, was: How do we fix her?

In May 1955, ten years after the end of World War II, twenty-five keloid-covered young women from Hiroshima travelled to New York's Mount Sinai Hospital for plastic surgery. The self-proclaimed 'Unmarried Young Ladies of Hiroshima' belonged to Methodist minister Reverend Kiyoshi Tanimoto's weekly support group for the severely scarred. They were re-named 'The Hiroshima Maidens' by goodwill ambassador and influential *Saturday Review* editor Norman Cousins, who was solicited by Tanimoto to help with his humanitarian cause. Dedicated to improving post-war relations between Japan and the United States, Tanimoto and Cousins, who met in 1949 while drafting human rights provisions for the new Japanese constitution, approached Cousins' personal physician, William Hitzig, to ask him to donate his time and medical expertise toward the reconstruction the Maidens' faces. Over the course of an eighteen-month long period, Hitzig, and plastic surgeons Bernard E. Simon, Arthur J. Barsky, and Sydney Khan, offered their services to the Maidens project, while Cousins recruited press to cover the women's physical and cultural transformations (Gaie 1996, 352–53). With support from the US State Department, which was committed to controlling the visible traumatic consequences of the atomic bomb, Cousins envisioned and realized a fundraising effort and publicity campaign that simultaneously veiled the women's wounds with plastic surgery and covered up a steadily increasing US public concern over government funding and support for nuclear and hydrogen weapons research (Gaie 1996; Serlin 2004).

The history of the Hiroshima Maidens is a history of surviving the atom bomb. Thus, it is a history of trauma, of living through a disaster and living with the psychological scars it leaves behind. More than a historical event, the Maidens' tale is a psychoanalytic parable that illustrates the impossibility of remedying mental scars through the reconstruction of their corporeal correlates. As Cathy Caruth argues, 'psychological trauma does not occur in strict correspondence to the body's experience of a life-threat, that is, through the wounding of the body' (Caruth 1996, 60). But if physical and psychological wounds are connected arbitrarily, why then did the United States government as well as private American citizens invest so much time, money, and thought into rehabilitating the faces and bodies of the Hiroshima Maidens?

In this paper, I will trace the atomically wounded Japanese face in order to illustrate how the Maidens' story is a fable about failure; the United States' failure to manage Japanese trauma (cf. Kaplan 2005, 66), and control and contain what Caruth calls 'an overwhelming experience of sudden or catastrophic events in which the response to the event occurs in the often delayed, uncontrolled repetitive appearance of hallucinations and other intrusive phenomena' (Caruth 1996, 11). My objective is to firstly expose how the Hiroshima Maidens mutilated faces were manipulated signifiers, constantly and visibly contested through pictures and discourse, as well as across national borders and languages. I will thereafter argue, following cultural anthropologist Lisa Yoneyama, that the Hiroshima Maidens' actual faces and mediated images were, like other 'residues of Hiroshima's catastrophe [...] being recuperated for the establishment of coherent national narratives and identities' (Yoneyama 1999, 217). That is, the Maidens' story is illustrative of the United States' post-war effort to contain and control the physical, and visual, repercussions of atomic war so American culpability was assuaged, and the decision to drop the nuclear bomb appeared clearly warranted.

While Caruth, influenced by psychoanalytic theories developed by Sigmund Freud (that I will discuss later in this paper), claims that a physical wound is a 'simple and healable event,' I allege that the wound and the scar it produces are complex and have corporeal, psychological, social, and political consequences (Caruth 1996, 4). As Petra Kuppers writes of scars, they indicate a 'place' where the body 'becomes unfamiliar, [where] sense, perception, and meaning making become experiential as spatial and temporal phenomena' (Kuppers 2007, 1). The scar, in other words, is hardly superficial; it marks a change the body's experience of the world and a shift in society's perception of the body. Thus the medical effort to remove the scar is significant for it is an attempt to alter the body's experience and its perception. The Hiroshima Maidens' overlapping nuclear and surgical scars silently speak to the role of the visibly wounded body in a particular historical and cultural moment. The scars, and the public effort to repair them – to make the unfamiliar more familiar – demonstrate that that which lies upon the surface can expose traumatic experience otherwise isolated from consciousness. In the Maidens' story, the traces of individual and cultural trauma repressed within the collective historical unconscious are corporeally evident. What is more, the process of traumatic repression is performed through medical procedures and the dissemination of visual materials documenting those procedures.

Part I: I Can See the Light

Before everything went dark, thirteen-year-old Shigeko Sasamori saw a beautiful silver plane. She remembers pointing it out to a classmate just before a strange light swallowed her vision and a powerful force knocked her body to the ground. The days and nights that followed were filled with the stench of rotting bodies, intensified by a hot August sun. Shigeko was alone, hungry, thirsty, and disabled by a pain she could not comprehend. By the time Shigeko returned to her family, traces of the atom bomb were permanently fixed upon her face. Each scar was a mark of shame, a representation and reminder of a traumatic moment Japan was eager to inter. So, for the next ten years, Shigeko hid from sight, avoiding the disapproving public gaze (Gaie 1996, 352).

The landscape of post-war Hiroshima, decorated with new highways, office buildings, public transportation and modern services, illustrated a deep-seated commitment to the concealment of geographic scars. The urban regeneration of Hiroshima, and the regeneration of Japan more generally, was funded by billions of dollars in US grants, quickly re-established a bigger and better industrial centre, built in the image of its benefactor. In a 1955 *Saturday Review* article, Cousins reports 'Hiroshima is on its way to becoming one of the most exciting cities, architecturally, in Japan' (Johnson 1988, 50). The architectural reconstruction of Hiroshima, well recorded and publicized in both Japan and the United States, successfully covered atomic pockmarks littered across the surface of the city. These were engineered into invisibility. But architects and planners were not equipped to contend with the scarred bodies belonging to burn victims like Shigeko. Nor, as Lynne Luciano writes, were Japanese doctors as short on essential medical supplies as they were on expertise. Understandably cautious not to 'inflict more trauma than the bomb' these doctors eventually called 'a halt to their ineffectual cutting' (Luciano 2001, 66). Without medical recourse, Shigeko and her atomically burned sisters, unfortunately nicknamed 'The Keloid Girls', were fated to live with their scars in a social and geographic landscape undergoing an otherwise apparently successful reconstruction. Painfully aware of their country's social and architectural efforts to repress the physical and psychological vestiges of atomic war, including the marks upon their faces, the scarred women only left their homes in the dark of night, or, if necessary, during the day, with their corporeal archives of atomic encounter covered by veils (Gaie 1996, 352).

While images of Hiroshima's architectural ingenuity were published in the pages of Japanese and American post-war periodicals, Japanese bodies were omitted from the photographic frame. Thus, the bodies of Hiroshima survivors were absent from the collective American post-war imagination. Censored into invisibility, scarred Japanese faces became hard to imagine. Cultural historian David Serlin points out that it was not until late 1952 that photographs of the victims of the atomic bomb were published in American magazines or newspapers (Serlin 2004, 66). The visual sanitation in the years following the war was not coincidental. After the Japanese surrender, the US government's Civil Censorship Division of the Occupation declared stringent censorship on images and discourse that referenced the bomb. The new governmental edict stated that 'nothing shall be printed that might, directly or by inference, disturb public tranquility' (Levy 2009). Accordingly, American publications unanimously responded with images that distanced

the viewer from Japanese bodies and faces, focusing instead on buildings ravaged into splinters and abstract aerial photographs. The press recognized that pictures, as well as descriptions, of people in pain were off limits, as they would disturb the post-war public, who were relatively ignorant of the effects of the bomb on human bodies.

A number of photographers and journalists were individually censored. The Japanese photojournalist and atomic bomb survivor Yoshito Matsushige, for one, had his photographs of the nuclear aftermath confiscated and not returned until 1952, years after the war had ended (Gusterson 2009). One of Matsushige's black and white photographs, published in *Life Magazine* on September 29, 1952, and taken hours after the bombing, depicts a policeman providing first aid. Matsushige remembers his hesitancy behind the lens and the guilt he experienced with each flash of the shutter:

There I saw a crowd of people whose burned skin was slithering off them. As time went by, the street filled with more people so hideously injured that even their gender was unclear ... What did these people at death's door think of me as I recorded this scene in photographs?

(Hiroshima Virtual Museum Exhibit 2001)

The chaotic moment the photographer describes is crystallized by his technology into something physically tangible, still, and silent. The borders of the photographic frame materially contained the disaster, but the visual manifestation of pain and desperation conveyed by Matsushige's picture emanated beyond the bounded image. General Douglas MacArthur, Supreme Commander of the Allied Powers in Japan, and a principal proponent of suppressing photographic records of radiation-ravaged Japanese bodies, ironically acknowledged the power of Matsushige's photograph through its firm censorship.

Determined to simultaneously move on from the horrors of the war and celebrate American victory, the State Department's motivation to conceal the photographs is complicated. As Gar Alperovitz notes, the United States suppressed images of the war not only out of fear of criticism, but also to maintain a reputation free of the 'inhumane or barbaric' associations (Alperovitz 1995, 611). The effort suggests that photographs like Matsushige's were too close, and too viscerally charged with real pain, to convey patriotic triumph. By burying disturbing images of the physical consequences of atomic war until the American Occupation of Japan ended in April 1952, MacArthur temporarily silenced the embodied testimony of countless Japanese victims, and perhaps even attended to his own latent guilt (Saito 2006, 9). The decision to manufacture an American media landscape free of human suffering propagated a collective national myth premised upon visual absence, a story of atomic war without corporeal casualties. As with all good myths, spoken and unspoken, this one was created as a means of contending with the otherwise incomprehensible. In her book, *Regarding the Pain of Others*, cultural critic Susan Sontag discusses the impossibility of looking at photographs of atomically ravaged victims. She notes that pictures of 'faces melted and thickened with scar tissue ... are pictures whose power does not abate, in part because one cannot look at them often' (Sontag 2003, 83). More than a visual record of war, Sontag claims, these pictures are a form of testimony. The scars upon the bodies of the individuals who were exposed to the atomic bomb are a true confirmation of war's human consequence. Even without

textual commentary, they effectively communicate the raw reality of physical trauma, and thereby the power of the visual that MacArthur, due to his involvement with The Civil Censorship Division of the Occupation, so ardently suppressed.

Like the trauma associated with the event itself, Matsushige's photographs, and the open wounds they portrayed, could not be suppressed forever. As Caruth suggests '[t]he historical power of the trauma is not just that the experience is repeated after its forgetting, but that it is only in and through its inherent forgetting that it is first experienced at all' (Caruth 2005, 17). Freud too argues for the importance of forgetting as part of the experience of trauma. For Freud, to forget is to contain or isolate experiences outside of consciousness, to filter pain from everyday life. In *The Interpretation of Dreams*, Freud writes 'we often forget in obedience to a purpose of the unconscious, and that forgetfulness always enables us to form a deduction about the secret disposition of the forgetful person' (Freud 1938, 241). What we forget, neglect, or leave out, in other words, is often the event that defines us, ultimately motivating us to make the decisions we do. For, as Freud advocated throughout his career, 'unconscious mental activity permanently determines, gives form to, and participates in our conscious life' (Surprenant 2006, 199). The conscious and unconscious are linked, ever informing one another. So while forgetting is 'essential to civilization', for it allows people to live without constant conscious overwhelming pain or desire, avoiding traumatic memories is futile (Rivkin and Ryan 2004, 389). Experiencing the trauma housed within the unconscious is inevitable because, according to Freud, traumatic memories sequestered in the unconscious seep through into the conscious. They show up, most notably in dreams, but also arise as repetitive neuroses that interrupt and determine the actions and interactions of waking life. Often unrecognizable in new their form, traumatic memories appear and reappear in a variety of guises, claiming their power over the mind and the body.

The mental and physical symptoms of trauma attest to the 'failure in repression.' Freud demonstrates that this 'failure' is as relevant to the experience of the individual as it is to society (Freud 1964, 183). As objects of trauma and symptoms of the US government's guilt-laden effort to conceal, deny, and ultimately forget, the photographs of atomically ravaged Japanese bodies, contributed to their eventual materialization. That is, if the photographs of disfigured bodies in the midst and aftermath of the bomb are of themselves material manifestations of a historical trauma, it was their official denial that ultimately fuelled their subsequent publication in *Life Magazine*, and motivated their dissemination thereafter.

Part II: Look, Don't Touch

One day after the keloid scarred women left Tokyo, the US State Department sent a telegram to the American Embassy in Japan expressing concern that,

[the] Hiroshima girls['] medical treatment in [the] US can generate publicity harmful not only [to] our relations with Japan but particularly [to] our worldwide efforts to avoid playing up [the] destructive effects [of] nuclear weapons

(State Dept. Files 1955, cited in Serlin 2004, 74)

If this telegram had arrived twenty-four hours earlier, Serlin (2004) contends, the Maidens may never have left Japan. As it was, the Maidens were well on their way to New York, and the State Department found themselves on a reconnaissance mission to salvage whatever Americanist propaganda they could from the Maidens' medical sojourn in the United States.

Shortly after the Maidens arrived in New York, Cousins met with Walter C. Robertson, Assistant Secretary to the Far East for the State Department. The men discussed a strategy for introducing the young women to the American public. Their mutual intent was to suppress the United States' part in the injuries suffered by the girls by creating patriotically altruistic rhetoric. If successful, the Maidens' marketing campaign might also stave off dissent against nuclear and hydrogen testing. Theirs was a campaign of forgetting what did happen and what could happen. Robertson and Cousins quietly, yet forcibly, constructed a declarative culture of surfaces; questions and doubts regarding the efficacy of atomic warfare were buried like the atomic impressions upon Hiroshima's landscape, Matsushige's photographs of mutilated bodies, and the silent psychological scars that belonged to every individual who experienced the bewildering light that preceded bewildering darkness.

The State Department's concern that American medical treatment of Japanese survivors could be interpreted as an official US apology for the bombings (Lindee 1994, 138) began with the Atomic Bomb Casualty Commission (ABCC). The ABCC, established in Hiroshima during the Occupation, was created to 'diagnose radiation illness but not treat it' (NuclearFiles.org 2012). Based first at The Red Cross building in Hiroshima, and afterward on a hilltop in Hijiyama Park, the ABCC studied the effects of atomic warfare by examining the victims of the bomb. Their findings were recorded and purportedly used for consulting purposes. Through the ABCC, the US government entered into the country-sized petri dish it had created. The rules in this environment were clear: look, but don't touch. By refusing to medically intercede in Japan's atomic aftermath, the ABCC established a hands-off precedent. While American curative technologies were developed by doctors and scientists in Japan, and produced in response to tests on Japanese 'subjects', they were unavailable to Japanese victims of the atomic bomb. Ultimately, the ABCC celebrated American medical innovation while refusing to treat a country in pain.

The Maidens project circumnavigated issues of post-war American atonement insisting that:

the common standards of war, the treatment accorded wounded enemy soldiers or civilians under military occupation, for example, suggest that medical care is not necessarily linked to moral responsibility for an injury ... Medical treatment is not generally construed by either side as an apology or admission of guilt

(Lindee 1994, 141).

The Maidens' medical treatment, then, was not a confession, or a show of remorse. Rather, Cousins, the Maidens' doctors, and their hosts felt they were involved with a goodwill enterprise, addressing the needs of the less fortunate. The popular discourse and visual representations of the women before and after their treatments depicted the medical and moral transformation as the result of a benevolent intervention. According

to Cousins, and the Maidens themselves, the girls were grateful for such an opportunity (Sasamori 2009). In the opinion of Ellen Cousins, wife of Norman, '[t]he loving warmth and concern shown to the girls by their host families made it possible for [them] to regain their self-confidence and self-esteem and to eliminate the shame they had previously felt about their scars' (Gaie 1996, 353). Bernard Simon, one of the plastic surgeons who treated the Maidens in New York, agreed. In a 1985 interview he compared the young women's collective medical metamorphosis to 'watching a beautiful flower open' (Gaie 1996, 353). According to Simon the girls transformed emotionally and culturally as much as they did physically. Whether or not the Maidens felt legitimately indebted to Cousins, Tanimoto, and the American volunteers is difficult to know, given Cousins' control over their interviews and images. For what it is worth, the mediated Maidens, who inhabited the simulated spectacle Cousins constructed for and around them, publicly attributed their American friends and benefactors for providing them with a (second) chance to lead 'normal lives' (Gaie 1996, 353).

Outside of Cousins and Tanimoto's public investment in the Maidens, a number of individuals were necessary for the apparent success of the project. The Maidens' story is full of unsung heroes: the Quaker families who volunteered to house the women during their recovery, the surgeons and nurses who offered their time, skill, and hospital beds, and countless people who donated money to support the medical procedures. All those involved came to epitomise a kind of humanitarian patriotism that uncannily resembled the benevolent monarchical impulse of colonial missionisation practices. The conquered were saved by the conquerors, and the conquerors thereafter demanded accolades for their salvation. This self-congratulatory sentiment resonates throughout a report from the *New York World-Telegram* of the 9 May 1955 which reads: 'for years [the Maidens] have avoided society's gazes and stares, helpless in their common sorrow. But now there is hope ... Twenty-five Japanese girls are seeing what America is really like' (cited in Serlin 2003). The Maidens experienced stigmatisation in Japan, but were hardly the spectacles they became during their sojourn in the United States. Their experiences of America – at Mount Sinai, with their host families, and during the public relations campaign – in no way resembled those of the average foreign tourist. The Maidens were not tourists; they were the main attraction.

Part III: Other Others

The Maidens were the first *hibakusha* – victims of the atomic bomb – that the post-war American public ever encountered face to face. It is a significant irony then that the first faces Americans saw were also the first faces they attempted to reconstruct. Images of the women's faces and bodies were scrutinised in the press, and circulated through philanthropic circles with pleas for further funding. The discomfort this attention produced for the girls must have been unimaginable considering their former isolation, as well as language and cultural barriers, amplified by the general self-consciousness nearly all young women feel when they are made aware of their physical flaws. Additionally, the Maidens' eighteen months of intense visibility recorded the girls' faces as they underwent painful skin grafts. Collectively, the women participated in



Figure 8.1. Nurse serving lunch to patient (Copyright: Bettmann/CORBIS, U1295978INP).

140 surgeries (Gaie 1996, 353). Somehow they managed to smile through it all – or at least that is what the pictures tell us.

Photographs of the women smiling in their hospital beds, on day trips with their Quaker families, and in front of aeroplanes upon their arrival in the US and prior to their departure, accompanied newspaper stories about hope and physical reincarnation. Serlin notes that the girls even composed an a cappella pop song entitled 'Smile, Please Come Back' released as a single in Japan (Serlin 2004, 92). The Maidens' apparent happiness was fundamental to Cousins' State Department approved plan. Here, photographs were censored from within the frame. Bodies could *be* in pain as long as it *looked like* they weren't. The positive and sympathetic public response to the images is a testament to the power of specular signifiers and highlights the relationship between aesthetics and ideology (cf. Kaplan 2005). The American public of the 1950s, enamoured by the possibilities of the modern televisual world, lived by the mantra that believing is seeing. Images were truths, aids to assuage doubt and confirm the story.

The photographs of the smiling Maidens were proof of their happiness; America made these girls smile and the camera fixed the smile upon their faces for posterity.

The Maidens' reconstruction was highly visible, but a singular televised incident simultaneously veiled the women's faces and revealed the traumatic fault lines in Cousins' marketing campaign. On the 11 May 1955 Reverend Tanimoto, his family, and two of the women, Toyoko Minowa and Tadako Emori, appeared on NBC's reality show *This is Your Life* 'with the intended goal of raising money to help pay for the Maidens' surgeries' (NBC-TV 1955; Serlin 2003). Producers asked Minowa and Emori to sit behind a screen 'to avoid causing them any embarrassment' (Serlin 2004, 90). Because the women's faces had already been publicised by newspapers, the producers' argument for their visual anonymity appears an unconvincing disclaimer at best. Rather than protecting the women, the screen protected the audience from viewing the physical ramifications of nuclear war. Visually and spatially separating the women from the other guests, host, and viewers, the screen positioned in front of the women was a physical manifestation of the prevailing American post-war ignorance of nuclear-devastated Japan.

As silhouettes, Minowa and Emori represented a shadowy unknown Japanese 'Other', ethnically and psychoanalytically distinct from the Western audience who watched the show. Literally and figuratively profiled, the women sitting behind the screen conveyed a layered alterity; differentiated from the white American body because of their ethnicity, physical disfigurement, and lack of specific subjectivity. As psychoanalyst Jacques Lacan argues, the presence of the Other is necessary to the constitution of the self; '[t]he Other is the locus in which is situated the chain of the signifier that governs whatever may be made present of the subject – it is the field of that living being in which the subject has to appear' (Lacan 1998, 203). That is to say, the presence of the Other – in this case the keloid scarred Japanese female body – is evidence of an antithetical collective Western subject, an American post-war identity premised upon not being Japanese and not being scarred. As part of an oppositional structure, the Japanese 'Other' codifies the American subject that *knows who he is because he knows who he is not*.

While the scarred women were shown in profile behind the screen, producers asked Tanimoto's Westernized wife, Chyssa, to change out of her modern American clothing into a kimono and slippers. Even as *This is Your Life* forced the Maidens into virtual invisibility behind the screen, the show sought to visibly 'celebrate the exotic authenticity' of the Other (Zizek 1999). Her identity superficially re-constructed, Chyssa served to represent a docile and 'traditional' Japanese woman unchanged by nuclear war. Chyssa's identity, like the Maidens' lack of identity, was fictional. Neither Chyssa, in the traditional Japanese clothing that the producers provided, nor the Maidens, in profile, portrayed a post-war Japanese woman with any accuracy. However, fidelity was never the goal.

Interestingly, Naoko Shibusawa notes that Cousins', who was the Maidens primary American advocate, never extended medical treatment to any hibakusha men. Shibusawa convincingly argues that his neglect of adult men was more than simple oversight. She writes, with regard to Cousins' investment in the Maidens project, and his ongoing support of the 'moral adoptions' program for Japanese children orphaned by the bomb:

... *Saturday Review of Literature* editor Norman Cousins, predictably chose Japanese women and children as the beneficiaries of their aid...both programs neglected the adult male victims of the atomic bomb, providing yet another example of the postwar interpretive framework that cast the Japanese as the dependents of a big-hearted and wise US breadwinner, protector, and parental figure.

(Shibusawa 2006, 216)

This in mind, the televisual dynamic between the silent Maidens' in silhouette and the show's host, Ralph Edwards, is especially noteworthy. While it appears Toyoko Minowa and Tadako Emori have a microphone (also visible in silhouette) they remain completely silent. Edwards refers to them, but never engages with them. He infers that they are behind the screen for protection because revealing their scarred faces to the American public would be too emotionally draining for the women. Here, Edwards, as the representative of *This is Your Life*, plays the role of 'protector.' But his concerned paternal script leaves the women no opportunity to tell their own stories. While there was certainly the issue language barrier, the show did not provide a translator that night. Ultimately, then, the individuals involved with Tanimoto's *This is Your Life* episode had no intention of humanizing the women. In shadow, and without voice, the women were infantilized. Like children in the company of a parent, they were spoken about, but were not directly addressed.

The *This is Your Life* episode that featured the Tanimotos and the Maidens may have easily been the most traumatic in the show's history, for it was host to the first and last encounter between Lieutenant Robert Lewis, co-pilot of the Enola Gay, and the victims of the bombing (NBC-TV 1955). It is rumoured that prior to the televised meeting between Lewis, Tanimoto, and the Maidens, the former pilot spent the day drinking his anxieties away (Serlin 2003). No doubt, Lewis, an alcoholic, had to calm his nerves before publicly recalling his experience of the 6th August 1945. Lewis responded in a trembling voice:

Well, Mr. Edwards, uh, just before 8:15 am Tokyo time, Tom Ferribee – a very able bombardier – carefully aimed at his target, which was the Second Imperial Japanese Army headquarters. At 8:15 promptly, the bomb was dropped. We turned fast to get out of the way of the deadly radiation and bomb effects. First was the big flash that we got, and then the two concussion waves hit the ship. Shortly after, we turned back to see what had happened. And there, in front of our eyes, the city of Hiroshima disappeared. I wrote down later, 'My God, what have we done?'

(Serlin 2004, 88–89)

After his short monologue, a wide-eyed Lewis handed Tanimoto a cheque for 50 dollars to go toward treating these Japanese victims of the bomb. Edwards encouraged the two men through an awkward conciliatory handshake. This exchange must have been unnerving for all parties involved. But it may have had the greatest impact on Lewis. Shortly after the show, the former pilot was diagnosed with depression and mental illness. He spent the latter part of his life in an upstate New York mental institution constructing a large mushroom cloud sculpture with a stream of tears issuing from its centre (Serlin 2004, 89).

Lewis' obvious on-air remorse did a great deal of harm to Cousins' State Department endorsed plans to reconstruct American altruism without apology. As Robert Jay Lifton observes, 'The reporting in Hiroshima of an expression of repentance ('What have I done?') by [...] Robert Lewis, after meeting the Hiroshima Maidens, had considerable meaning for some hibakusha' (Lifton 1991, 341). Lewis wanted forgiveness. He had a guilty conscience because he knew dropping the atomic bomb caused casualties beyond the expected crossfire of war. Lewis' regret incriminated all of America and compromised the efficacy of the Maidens Project, but it also initiated a slew of donations from viewers across the nation who felt pangs of compunction from the comfort of their living rooms. As the cheques for the Maidens' reconstructive needs poured in, national guilt was superficially alleviated, and the consequences of the bomb further repressed. Cousins may have given the Maidens new faces, but his gift to America was far more valuable. He granted Americans distance from the war's horrific aftermath and endowed them with the peace of mind that they had done everything they could for the Japanese survivors. Cousins' prescription for post-war American guilt was simple and took little time and energy: write a cheque, send it in, and feel better.

Was Cousins wrong to seek cultural reconciliation? Was he manipulative because he hoped to repair America's image, as the surgeons he recruited restored Japanese bodies? Probably not, but he is guilty of displacing his culpability onto the faces of twenty-five young women. His self-reproach not only shaped their faces; it ultimately moulded their lives. One of the Maidens, Tomako Nakabayashi, died of heart failure during her third surgical procedure. Another, Hiroko Tasaka, married taxi driver Harry Harris who proposed to her following her television appearance (Barker 1985). As for Shigeko, she was adopted by the Cousins family and lived with them for over two decades. Her only son, Norman Cousins Sasamori, was named after the American father who modelled her into the woman she became. For all of Cousins political propagandising he definitely 'turn[ed] trauma into opportunity'; his actions allowed Americans and Japanese to forget the war and remember the reconciliation (Serlin 2004, 102).

Part V: A Cry So Loud

When Lewis appeared on *This is Your Life* he confronted Reverend Tanimoto, his wife Chyssa, and the Maidens, whose presence was mitigated by the screen partition. With this meeting, Lewis' victims became real people; they had faces (or at least the shadows of faces), voices, and memories that were inalterably linked to his own. In the NBC television studio, ten years after Lewis fled Hiroshima air space, his absent victims became present. The once distant and nameless casualties of war in close physical proximity, Lewis confronted the disturbingly apparent psychological and corporeal repercussions of his actions. Lewis' encounter with the survivors visually and tangibly confirmed that the atom bomb made it to the ground, and that its impact had been more than aesthetic. Lewis may have witnessed a powerful flash of light subsuming the landscape below, but the Maidens experienced the inassimilable force of a nuclear weapon. For Lewis, and many Americans who watched *This Is Your Life*, seeing post-war Japanese bodies, and acknowledging the pain of post-war Japanese subjects, summoned

the formerly invisible Other into visibility. The physical presence of the survivors of the atom bomb compounded Lewis' latent realization that he was intimately implicated in modifying bodies and altering lives. It is this trauma, and its symptoms, that Lewis experienced until his death.

Freud's classic psychoanalytic text *Beyond the Pleasure Principle*, first published in 1950 and revised in 1961, sheds light on Lewis' reaction to the Maidens' and his initially dormant but eventually crippling traumatic reaction. In this book Freud considers Torquato Tasso's 16th century Romantic epic *Gerusalemme Liberata*. Freud's version of the tale is:

Tancred unwittingly kills his beloved Clorinda in a duel while she is disguised in the armour of an enemy knight. After her burial he makes his way into a strange magic forest which strikes the Crusaders [sic] army with terror. He slashes with his sword at a tall tree: but blood streams from the cut and the voice of Clorinda, whose soul is imprisoned in the tree, is heard complaining that he has wounded his beloved once again.

(Freud 1961, 16)

Freud's reading of Tasso's story serves to illustrate the psychoanalytic notion of transference, or the compulsion to repeat and reanimate 'painful emotions...with the greatest ingenuity' (Freud 1961, 15).

As Ann Pellegrini observes, '[t]he retelling of Tancred's story, and Clorinda's, is extremely brief ... [it] ... does not even amount to a full paragraph in Freud's text' (Pellegrini 2009, 241). In this short passage, the father of psychoanalysis concisely demonstrates that the psychological trauma associated with an event can be masked, but never disappears. Tancred does not begin to recognise his suffering associated with Clorinda's death until he leaves battle and enters the forest. In this unfamiliar setting, away from the site of the traumatic event, Tancred unwittingly repeats the moment he stabbed Clorinda by piercing the tall tree that speaks to him in the voice of his lost love. The voice that issues from the gash in the tree sounds like Clorinda, but as Freud – and Caruth after him – explain, it does not belong to her alone. Nor, for that matter, does it simply emanate from the tree, which is a symbolic substitute for Clorinda and testament to the ingenuity of traumatic transference. The wound addressing Tancred in the forest is the sound of Tancred's inassimilable guilt: the voice of living through and with trauma.

In Caruth's interpretation of Freud's reading of *Gerusalemme Liberata* she writes that the voice Tancred hears – the crying wound – 'represents the experience of an individual traumatized by his own past – the repetition of his own trauma as it shapes his life' (Caruth 1996, 8). Caruth's representation of Freud's analysis complicates the original reading. For Caruth, Tancred's trauma is ever bound to Clorinda's; 'the wound that speaks is not precisely Tancred's own but the wound, the trauma, of another' (Caruth 1996, 8). Tancred shares the trauma of the event with his dead Clorinda. Here, it is evident that trauma is the product of an encounter that binds two (or more) individuals. Even as it is repressed, trauma unites the traumatised. Although the painful incident remains outside of daily consciousness, the voice of the other screams for recognition in the subject's mind, and manifests in every traumatic repetition. Clorinda's trauma was a part of Tancred, like the Maidens' trauma was part of Lewis. Clorinda's voice, contingent

upon the repression of the traumatic encounter, lived in Tancred's unconscious forever, as the voice of Lewis' victims haunted him, and ultimately led to his psychological unravelling.

More than once, one could imagine, Tancred muttered the words of Robert Lewis, 'My God, what have I done?' Like Tancred, Lewis killed 'in error ... but ... on purpose' (Caruth 1996, 2). Similar to Tancred, Lewis was purposefully violent but relatively unaware of the humanity of his faceless victims or the extent of his action. With the benefit of hindsight Tancred and Lewis, as well as many of the Americans who supported atomic war, realised the consequence of their blind decision. Yet, Tancred and Lewis only acknowledged the repercussions of their destructive encounters after what Freud and Caruth both call a 'latency' period: a period of dormancy during which trauma develops (cf. Caruth 1996). It was during this period that Lewis' trauma became unbearable. The television encounter with Tanimoto and the scarred women unequivocally called his regret to the fore. Although he never saw the scarred faces of his victims, the meeting with the Maidens forced Lewis to face the historical trauma in which he was intimately implicated.

Freud and Caruth both establish that traumatic psychological wounds never close. But what of the physical wound that heals to become a scar? What of the traces of trauma written upon the Maidens' faces? Clorinda's wound was her death, but those who lived through the atomic bomb also lived with the scars of death narrowly averted. While the Maidens' psychological wounds were not immediately evident, their bodies betrayed the severity of their traumatic experience. Their psychological scars had obvious physical correlates; the corporeal scar is a permanent marker of the traumatic encounter. Invested in the activities of unconscious rather than in what traumatic encounter literally *looks like* upon the skin, neither Freud nor Caruth ever acknowledge the connection between physical and psychological scars. While Freud does contend that the body expresses symptoms of the mind, the scar is not a psychological symptom. Unlike the symptom, the scar is not necessarily a marker of unconscious mental distress. The wound appears during rather than after the event of causation. The scar does not surface or manifest; it is the wound's trace. While the symptom, as Linda Edwards and Michael Williams write, 'operates as an explanation – as the present trace of an absent cause', the scar is ever-present (Edwards and Williams 2006). If the symptom wilfully refuses repression, the scar is a mark of encounter that cannot be repressed. More corporeal than psychological, external than internal, the scar is a sign of possible traumatic encounter that belongs to the body but at least in the Maidens' case has complex and interrelated social and psychological implications. Its conspicuous presence is an indication that some trauma is visual and a sign of the futility of repression.

Delineating the scar from the symptom is integral to comprehending how the Maidens' story is different from other incidents of traumatic encounter. The Maidens' scars did not appear on the girls' bodies as a result of their psychological distress. But like traumatic symptoms, the Maidens' scars were external indications of the trauma they housed within. The women's unconscious minds and their bodies both testified to the unspeakable experience of living through the atomic bomb. Yet their physical appearances clearly and painfully iterated what their minds, and their culture, repressed. Each physical scar upon the girls' skin marked the moment of the event,

and the body's proximity to the atomic bomb. Collectively, the women's scars were a physical archive and testament of the destructive power of atomic energy. Even when the Hiroshima Maidens' suppressed their traumatic experience, their bodies revealed it. In so doing, their skin became an ever-present reminder of the choice the American government made in order to end the war.

Conclusion: Impossible Erasure

When The Hiroshima Maidens returned to Japan they did not get the response that Cousins had anticipated. No one celebrated their homecoming. They remained stigmatised. But, like their faces, the stigma that followed the Maidens was transformed. The Maidens were once signifiers of Japanese victimisation, but after their surgeries their faces became symbolic of invasive Americanisation. 'When none of the Maidens showed an interest in political activism, and collectively they did nothing to enlarge the project beyond twenty-four individual experiences,' Rodney Barker writes, 'people began to say they must have been spoiled during their year abroad' (Barker 1985, 187). The Hiroshima Maidens had, in a sense, betrayed their country with their bodies. The sign of their unfaithfulness was written upon their faces. First through war and afterward through medicine, the United States constructed and reconstructed the Maidens.

The Maidens surgical reconstruction was a medical and cultural performance of repression. Because the Maidens' scars were physical they could not be contained by the unconscious. But their faces, like Hiroshima's post-war urban landscape, could be razed and rebuilt. And their photographed and televised images could, like so many pictures of Japanese bodies ravaged by nuclear disaster, be strategically censored or framed. By surgically manipulating the Maidens' scars and visually engineering how the Maidens' were portrayed in the popular American press, Cousins and his supporters were able to protect the US from the physical consequences of nuclear war. Ultimately and with relative success, the Maidens project hid trauma in plain sight.

There is a striking and revealing parallel here between Cousins and the US State Department's efforts to ameliorate the cultural and physical fissures produced by atomic war and those performed by Freud's daughter, Anna (a practicing psychoanalyst). Later in his life Freud suffered from cancer of the mouth that left him with a prominent physical scar. Aware of the embarrassment and anguish his facial flaw caused, Anna kept images of her father's cheek wound from the public. Donna Green notes that Anna 'thought if the general public were to see [her father] in the distress he was in that it would take away from his intellect' (Green 2000, 3). Apparently Anna considered her father's scar a signifier of weakness. She feared its visually dialectical power. The wound's exposure threatened to undo an otherwise 'unblemished public image of Freud' (Marinelli 2004, 41). Like the US State Department following World War II, Anna Freud's actions implicitly acknowledged the photograph's power for depicting physical pain and suffering. Anna wanted to maintain a cohesive and intellectually omniscient public image of her father to such a degree that she concealed his physical appearance. But by censoring pictures of her father, Anna, like American post-war propagandists – including the well-meaning Norman Cousins, who mediated the images of the

Maidens – never fully faced the fact that things had changed. With or without pictures, before and after medical intervention, bodies ruptured by trauma can never entirely recover, nor can the psychological scars beneath.

Anna's actions are especially notable considering her father never paid much attention to physical scars in his intellectual work. While he wrote prolifically on the unconscious' ability to contain and control traumatic memories he neglected an exploration of the meaning of the traumatic imprint on his own face. For Freud, the scar belonged to the external body; as I noted earlier in this paper, he and many of his colleagues involved with psychoanalytic inquiry regarded the scar as 'a simple and healable event,' detached from unconscious traumatic repression (Caruth 1996, 4). However, Freud's own experience with mouth cancer, and his daughter's reaction to that experience, as well as the Maidens' sojourn to the United States, and Cousins' mediated portrayal of the venture, suggests Freud's focus on the mind limited his understanding of the scar's role as a signifier of the traumatic unconscious. Freud's mouth scar, like the Maidens' layered keloid and surgical scars demonstrate that trauma is, in fact, as present on the exterior of the body as it is the interior of the mind. They show that although psychological trauma may not occur through the wounding of the body, the body's wounds and subsequent scars do have relevance beyond the physiological. The medical and visual treatment of scars too is related to the unconscious' efforts to repress traumatic encounters. Thus surfaces, and how they are negotiated, contain an undeniable psychological and social depth.

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9. Writing Stones and Secret Shrines: An Exploration of the Materialisation of Indigenous and Islamic Belief within West African Spiritual Medicine

Bryn Trevelyan James

Introduction

Indigenous healing in West Africa, and to a lesser extent the link between religious beliefs and medicinal practices, has been the subject of extensive anthropological and historical research (e.g. Field 1937; Tremearne 1969; Imperato 1977; Buckley 1985; Konadu 2007). Problematically, often only limited published data is available concerning the actual therapeutic processes offered, either due to researchers implicitly and explicitly reducing the role of healing specialists to paradigms such as that of the indigenous psychotherapist (Csordas and Lewton 1998, 436), or as a result of the inherent secrecy which practitioners themselves typically believed necessary to guard the power of their medicines (e.g. Lewis Wall 1988, 293–97). Hence, in this paper emphasis will be placed upon closer analysis of a sample of documented spiritual medicines in order to explore how the *materia medica* of a migrant community may reflect not only technical choices made in medicine preparation or use, but also the way in which these material practices are structured by frameworks of religious belief.

Drawn from fieldwork engagements in 2010 and 2011 with a group of traditional healers living amongst the Muslim migrant population of Madina *zongo* in Accra, the case studies of spiritual medicines presented throughout this article will be used to explore two interrelated aspects of the community's diverse, yet shared, medical culture. Perhaps the most striking feature is the syncretism between indigenous and Islamic religious beliefs that has emerged to meet a need for *lafia*, (holistic well-being) (Lewis Wall 1988, 170). The search for *lafia* unifies immigrant urban dwellers from across West Africa and in so doing combines often seemingly opposing cosmological systems. This syncretism is wrought materially through the weaving together of substances, preparation techniques, and ritual performances abstracted from their origins within indigenous and Islamic traditions. It both defines and defies the identities of the producers and recipients of such medicines, be they the healer who prays in the mosque by day and sacrifices in the bush by night, or a street vendor with their neck encircled by a bunch of charms including both portions of the Qur'an and herbs imbued with the power of the local spirits, called *al-jene*.

Such syncretic performance emerges from the other central facet of Madina's rich

medical culture: the creative agency of the healers known as *mallami* (see Hassan 1992, 44–77). It is these *mallami* who individually and collectively mediate between the often contradictory tenants of dissimilar religious practices to produce tangible therapies which satisfy the cultural expectations of a diverse migrant community. *Mallam* derives from the Arabic *mu'allim*, teacher, learned person (OED 1989), but is widely used as a general form of address for healers offering curative medicines based on both the Qu'ran and the indigenous traditions of the *mai-magani* (medicine man). Thus, whilst this paper concerns the details of particular therapeutic processes, it is also intrinsically grounded in the stories or biographies of the individual healers from whose medicinal knowledge each cure proceeds.

Through investigating the role of material culture in the curative practices of contemporary specialists, alternate archaeological interpretations may be indicated and a broader range of analogies presented. Crucially, by engaging with local participants, the ethnographic approach moves towards alternative definitions and research agendas which give 'credence and weight to indigenous, non-Western epistemologies of the material world' (Lane 2006, 402). Dialogues between archaeological and ethnographic studies of health and illness in West Africa have already added temporal depth to analysis of healing sites such as sacred groves (Insoll 2011a, 181–203) and shrines (Apoth and Gavua 2010, 217–31), long-term curation of curative plants (Lentz and Strum 2001, 148; Insoll 2003, 294), and medicine preparation tools in domestic settings (Anquandah 1997, 297). Secondary ethnographic analogies were drawn upon in each of these studies; however, recently ethnoarchaeologists have been challenged to 'act more as direct enablers of their ethnographic subjects' (Lane 2006, 417), incorporating local voices as primary sources. One successful outcome of this initiative may be seen in the findings of Esterhuysen (2008, 468–69), who, excavating at the Historic Cave site in Makapan Valley, South Africa, consulted a local healer, 'Magodweni', to identify the medicinal herbal substances and objects found there. Key to Esterhuysen's (2008) success was the continuity of belief and material practice in the curative traditions of the region. In the final section of this paper, contemporary results from the Madina project are assessed against archaeological findings from Apoth and Gavua's (2010) proximate excavation at the Accra Plains *Otutu* (shine) to explore the potential value of integrating the opinions of contemporary practitioners within interpretive discourses. The strength of such an approach is not in emphasising direct analogies, but rather in expanding explanatory frameworks diachronically, reincorporating non-Western paradigms in a culturally relative manner (Lane 2006, 417).

Such reemphasising of the practitioners role as creative agent is necessitated by the lingering, pejorative conception of 'traditional' African medicine as somehow static (Baronov 2008, 126), or capable of only imitation rather than innovation (Flint 2008, 17), hidebound as it were by the restrictive nature of inherited learning. In the following sections, after outlining the project background and contextualising the spheres of indigenous and Islamic religious healing, this notion of the 'traditional' healer as a passive repository of distant knowledge will be challenged. Firstly, by looking at the work of two cousins who seek to unite the spiritual power of local stone with the *baraka* (holiness) (Greenwood 1992, 287) of Qur'anic verse, and, secondly, a powerful *mai-jinya*, 'one who sees spiritually', producing a portable spirit shrine called a *kalo*,



Figure 9.1. 'Baba' Yahaya at his workspace using a pestle and mortar to prepare *magani-maayo*, 'the witches' medicine' (photo: Bryn Trevelyan James).

strengthened by the inclusion of *layoyi*, the classic Islamic charm. By exploring such creativity one also gains an alternate perspective concerning the continuities of practice which provide ideological substance for new forms of medicine. It is this continuity, perceived as an active rather than static process through the reweaving of old beliefs into fresh medicines, which marks the indigenous practitioner as a dynamic curator of knowledge: rich sources for indicating potential archaeological implications of past healing residues.

Project Background

Madina is a rapidly expanding sub-urban settlement located in the Accra Plains 10 miles north-east of Accra on the Dodowa road. Conveniently, as a researcher, it lies just 2

miles north of the University of Ghana, Legon. Geographically, the area proper is located between longitude 5° 39'30" and 5°40'30" and latitude 0°9'30" and 0°11' (Zaami 2010, 5). The study focused on Madina as it is one of the largest Muslim settlements in Ghana, with a population of over 76,000 people (Ghana Population and Housing Census 2000), the majority of whom patronise indigenous healers, according to Peil and Opoku (1994, 219). Many of these healers live and operate within one particular ward: Madina *zongo*, 'the stranger's quarter', a migrant district of a type common to West African urban centres (Kobo 2010, 71).

A key factor in choosing Madina as a research location was that its migrant population formed a heterogeneous community comprising people from varied social, religious and ethnic backgrounds – an effective microcosm for studying West African medical cultures and their material correlates more broadly. The diverse ethnic composition of Madina includes migrants from the Northern Regions of Ghana (Northern Region, Upper West Region, and Upper East Region), Akans, Chamba, Ewe, Ga, Mossi and non-Ghanaians from Benin, Togo, Burkina Faso, Cote d'Ivoire and Nigeria (Zaami 2010, 8). Such diversity expanded to religious affiliations, with numerous Christian denominations existing alongside various Islamic groups, and always just beneath the surface the continuing beliefs of African indigenous religions imported to the city by the incoming rural migrants. The *zongo* context, then, with its heterogeneous population, presents an almost ideal opportunity to investigate, in a resource effective manner, the material biographies and beliefs of healers operating across a similar diversity of regional traditions.

Two seasons of fieldwork, between September to November 2010 and 2011, supported by contacts in the Archaeology Department at the University of Ghana, including Dr Benjamin Kankpeyeng and Elvis Aboluah, centred on a group of healers and medicine suppliers (see Table 9.1). Supported by a grant from the Royal Anthropological Institute, the project had three broad, interconnecting aims: (i) document and indicate potential archaeological implications of specialist artefact assemblages, including substances and medicines – 'The Healer's Tools'; (ii) analyse the interplay between co-existing Islamic and indigenous religious belief; (iii) explore the role and identity of healers within the Madina community. Patience and the reassurance healers received about the aims of the research, which were explained in relation to the Islamic concept of *al-rihla fi talab al-'ilm*, 'travel in search of knowledge' (see Ibn Battutah (trans. Mackintosh-Smith) 1992) lead to an openness which exceeded initial expectations. Each practitioner was engaged with in-depth over the course of multiple interviews and periods of participant observation, essential for building the level of trust necessary for the sharing of medicinal knowledge generally kept a closely guarded secret (for example, Bledsoe and Robey 1986, 202).

A particularly rich picture emerged of the herbalist practices of the healers involved, especially thanks to those participants who more closely self-identified as *mai-magani*. Such 'medicine men' (Last 2004, 723), specialists in the use of plant materials, whose knowledge of substances is bound up with inherited structures of indigenous religious belief, generally knew a greater number of substance-based cures than those healers who considered themselves to occupy the role of the Islamic *mallam* (Stock 1981, 365). However, as yet, analysis of each 'natural' medicine is still on-going, samples having

Name	Gender	Age	National/ethnic background	No. spiritual medicines known	Notes
Yussif Issah Sandah	M	42	Northern Benin – Jugu ethnic group.	10	Cousin of Ali. Primarily a <i>mallamic</i> spiritualist healer.
Ali Jibreel Sandah	M	55	Northern Benin – Jugu ethnic group.	4	Cousin of Yussif. Preference for herbal medicines
Adamu Zakaria	M	57	Northern Ghana, near Bimbila – Chamba ethnic group.	3	Chief of the Chamba people within Madina. Primarily a herbal ‘medicine man’, <i>mai-nugani</i> , although also used spiritual treatments.
Omar Fabu	M	60	Burkina Faso.	2	Friend and neighbour of Adamu. Expert <i>ma’dori</i> , bone setter.
Abdallah Ibrahim Salifu	M	50	Burkina Faso – Moshi ethnic group.	23	From a respected family of Islamic healers. <i>Mallam</i> with extensive knowledge of <i>sammu</i> , ‘bad medicine’.
‘Baba’ Yahaya Osmanu	M	70	Northern Ghana, Nanlerigu, Upper East Region – Guruma ethnic group, Moshi.	10	Regarded as the most powerful healer. A <i>mai-jinya</i> (‘one who sees spiritually’), he attributed his abilities to the inheritance of <i>al-jene</i> (indigenous spirits).
Abdul Baki Mohammed	M	62	Northern Ghana, Eastern Region, Koforidua – Dindi Tribe.	2	<i>Mallam</i> operating a small commercial practice, specialising in <i>rubutu</i> and <i>duba</i> ‘fortune telling’.
Osmanu Yakubu	M	81	Northern Ghana, Kofuridua – Chamba ethnic group.	0	Husband of Elizabeth. Primarily a domestic, herbal healer.
Elizabeth Botchway	F	69	Ghana – Wimeba	0	Wife of Osmanu. Only female healer recorded. Primarily an <i>ungozoma</i> , native midwife.
Ibrahim Inyas Alkaolakhay	M	58	Ghana, Volta Region – Kadjebi.	xxx	Operates a substantial professional clinic specialising in ‘commercial’ herbal medicines.
Mercy Boama	F	30	Nigeria – Badon.	xxx	Works at ‘The Timber Market’, James Town. Assistant to ‘Mrs Mother’ for over 14 years.
‘Mrs Mother’ Alaja Mrifutu	F	50	Nigeria – Badon.	xxx	Works at ‘The Timber Market’, James Town. Third generation medicine supplier, having inherited stall from her mother and grandmother.

Table 9.1. List of local experts interviewed about spiritual medicine (SM) practices in Madina (Accra).

been submitted for specialist botanical identification. For this reason, and to more clearly facilitate exploration of the influence of belief upon medical practices, the focus of this paper is upon the 'spiritual' rather than the 'natural', herbal medicines produced by the healers.

Defining Concepts: Spiritual Medicine and Syncretism

Within Madina, to be a successful healer, one must provide both spiritual and herbal medicines (see Fig. 9.2). The latter are used to cure physiological ailments ascribed a naturalistic causation, which are diagnosed on the basis of 'visible' symptom configurations. From a Western perspective, this form of treatment is familiar; it mirrors the structures of allopathic medicine. A patient visits a specialist, is examined, and then prescribed substances believed to have pharmacologically active agents to suppress or eradicate the aberrant physiological conditions (Barbour 1997, 4). Defining the concept of spiritual medicine as it is understood and performed by the research participants is somewhat more complex.

Related to the role of the *mai-jinya*, 'one who is able to see spiritually', spiritual medicine, as practised within the Madina medical culture is best defined in two interconnected ways: spiritual healing attributed to the agency of a numinous or supernatural force; and those healing performances concerning spiritual entities such as *al-jene*, or dwarves. Spiritual medicine has numerous forms but as a component of indigenous practitioners' activities these may be categorised as types of 'distant healing' rituals. Distant healing is defined as mental efforts undertaken by a person or persons with the intention of improving the physical, emotional or social well-being of another, with or without physical intercession (Syed 2003, 46). This broad definition includes *du'a* (petitionary prayers), in which the practitioner formulates a request for a particular outcome on behalf of their client, often focused through the medium of a rite, the application of empowered substances, or the transference of a ritual object. For further examination of 'ritual' as both concept and action see the work of Catherine Bell (1992; 1997), and for an archaeological perspective refer to Timothy Insoll (2004).

As fieldwork progressed, and healers were engaged with the question of why particular threads of performance and substance became woven into specific healing processes, the recurring finding was that a successful *mallam* ought to be constantly striving to improve or conserve the *karfie* (strength) of their spiritual medicines. To assure such *karfie* the healer must draw upon, and ward off, the diverse supernatural agencies occupying the invisible spirit world in which they, and their patients, find themselves immersed (Danfulani 1999, 422). It is this belief in the perpetual obligation to vigorously solicit the power of Islam alongside a mosaic of indigenous religious traditions, catalysed by the healers' active, creative approach to strengthening their therapeutics, which arguably provides the conditions for syncretism within spiritual medicine across Madina. Before expanding upon the specific material practices emerging from this, it is useful to succinctly define what is to be understood when referring to the healers' combination of Islamic and indigenous beliefs as a syncretic process.

Within archaeological discourse syncretic processes present a temporal perspective

from which to consider religion as fluid and changing rather than static, exemplified by 'the blending or fusing of different religious traditions or elements' (Insoll 2005, 98). Across ethnographic studies of religion, syncretism is a much debated term, sometimes taken to imply 'inauthenticity' or 'contamination', the infiltration of a supposedly 'pure' orthodoxy by symbols and meanings seen as belonging to other incompatible traditions (Shaw and Stewart 1994, 1). However, the utility of the concept is widely accepted (e.g. Hartman 1969; Jensen and Leopold 2004; Maroney 2006). Within this paper, syncretic practices relate to actions or emergences which implicitly or explicitly move towards reconciliation between beliefs, traditions, or systems, providing an explanatory framework for considering both continuity and change over time.

The Unifying Search for *Lafia*

A central consideration when researching ultimately distinct medical traditions within a diverse migrant community is how to make sense of transferences and engagements between seemingly contradictory spheres of belief and practice. One possible answer to the difficulties of offering a cohesive analysis of a mixed medical culture is pointed to by John Janzen (1985, 73):

The therapeutic techniques and approaches taken to illness [...] in a therapeutic tradition are usually anchored ideologically in a wider system of beliefs, values, and cognitive realities.

In the case of the participant healers, despite the opposing tenets of indigenous and Islamic religious ideology at play, this anchor was grounded upon a unifying belief that illness and misfortune stemmed from an imbalance of *lafia*. *Lafia* connotes well-being in a holistic sense (Lewis Wall 1988, 112), and for ease of understanding can be related to humoural theory as it developed within Islamic medieval medicine (Lutz 2002, 60). Originating linguistically from Hausa, the shared language of West African Muslims, *lafia* is usually translated as 'health', for it often has implications pertaining to the proper state of the body. However, Lewis Wall (1988, 113) states a more proper translation would render *lafia* in a broader sense as a holistic state of 'peace' in all areas of life. Thus, as was the belief of the healers, the purposes of spiritual healing are all encompassing. It is a shared understanding of *lafia*, the balance of life, that provides the fundamental context of connection around which the intertwining of Islamic and indigenous religious beliefs has been negotiated on local terms.

Whilst in some communities, such as those studied by Masquelier (2001) in southern Niger, there was apparent bad feeling between faiths – Muslims openly condemning rituals of indigenous religious practitioners, whilst followers of traditions beliefs suspected Muslims of being hypocrites who secretly resorted to the practices they publically denounced – these tensions were more mediated in Madina. Healing in particular is a private world, and for one healer to openly confront another would be highly unusual. Local practitioners respected different bases of power and avoided direct conflict due to concerns for their reputation and fear of attack by spirits or bad medicine. Tensions in Madina then were not overt; orthodox Muslims did privately criticise

activities of spiritualists such as blood sacrifice and idolatry which transgressed Quranic law, but disagreements among healers were minimal, particularly as the local client base was broad enough to support a wide variety of specialists.

Islamic medicine

The Islamic activities of healers observed in Madina centred around two principle methods: (i) the performance of *du'a*, prayers and spiritual rites involving multiple repetitions; (ii) the production of written charms and invocations, containing the names of Allah or versus from the Qu'ran (Last 2004, 723). When producing spiritual medicines each *mallam* stated that prayer was the foundation of their healing abilities. Without the ritual of prayer, and the empowerment their actions received from Allah through this process, each believed any medicine they produced would lack *karfi* (strength). Before moving on to the materially visible aspect of such healing, it must be stressed that all spiritual medicines produced by the practitioners emerged from, and were enmeshed within, much wider ritual processes, processes characteristically structured by the healers' dual identity as an Islamic *mallam* and as an initiated *mai-magani* (medicine man): the inheritors of indigenous religious knowledge. As an archaeologist seeking to broaden ones interpretive perspective, it is an awareness of these ancestral threads of habitual practice and the intersection of religion and medicine in the dynamic act of healing, which enriches analysis of the otherwise static material dimension.

For the practitioners, encapsulating and conveying blessings derived from their ritual performances to clients was one of the key purposes framing the production of medicines. Islamic methods predominantly involve direct transfer of the Word of God from the Qu'ran into the bodies, and thus the lives, of their patient in tangible form (Abdalla 1997, 85). Techniques of transference are the subject of *batin* studies, known as the 'hidden sciences' (e.g. see Donaldson 1937, 254–66; Robson 1934, 33–43), an esoteric domain devoted to materialisation and control of numinous forces, using calligraphic and numerological formulas often incorporating *hatimi*, 'magic squares' (Prussin 1986). At the core of these longstanding practices is literacy, writing being strongly associated with the divine across African cosmologies. Jack Goody (1968), in his influential works



Figure 9.2. Mallam Baki: spiritual and herbalist. His sign illustrating the dual roles expected of indigenous healers within Madina (photo: Bryn Trevelyan James).

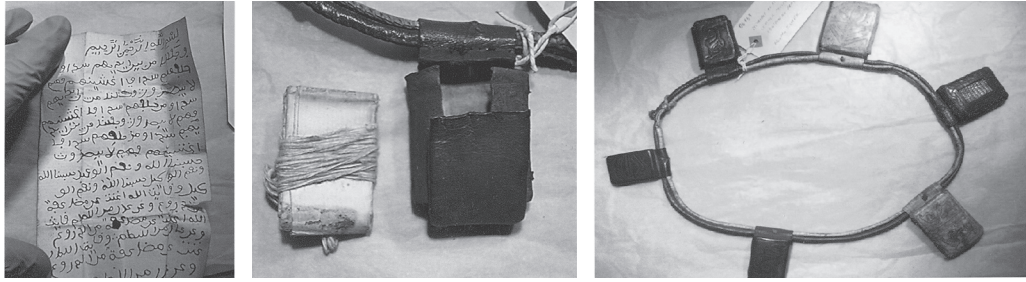


Figure 9.3. *Layoyi*: stitched leather packets containing Islamic inscriptions on paper, the classic West African Islamic charm. In this example we see an uncovered *laya*, the stitching having been unpicked by a previous curator. Note the three stages of encasement and materials used: ritual folding of paper; wrapping in cotton twine; enclosure in leather case. (Photo: Bryn Trevelyan James at Manchester Museum. Acc. No. 0.6959).

on literacy (Halverson 1992), argued that the very nature of writing as a purely symbolic form positions it as the ideal medium for communication between the natural, visible world of man and the invisible, supernatural world of spirits.

Among *mallamic* healers in Madina, like their colleagues across the Muslim world, the two dominant forms of Islamic literacy-based medicine documented were the practices of *rubutu*, often translated as ‘Drinking the Word of God’ (El-Tom 1985, 414), and the production of various *layoyi*, stitched leather packets containing Islamic inscriptions in paper (Prussin 1986, 84). *Rubutu*, due to the more open nature of its practice, has been far more widely studied, and as such it is better to point the reader to published material rather than repeat well known patterns here (Ahmad and Ibrahim 1996, 40–45; Abdel Halim 1939, 30–33; El-Tom 1985, 414–31; Mattson 2008, 159–60). The production of *layoyi* by contrast is far more secretive, as *mallami* closely guard their *al-kundi*, or ‘recipe books’ (Abdalla 1997, 143), since this compendium represents their stock-in-trade acquired from his teacher, or at a price from another professional (Rubin 1984, 67). Specific formulas are further guarded based on the belief that restricted knowledge retains greater power (Fodor 1990, 75).

The limited number of studies on the written content of *layoyi*, by ethnographers such as Abdalla (1997) and Hassan (1992), and art-historians including Heathcote (1974), Kriger (1988) and Rubin (1984), focus upon isolated examples by individuals, or translations from historic sources (e.g. Elgood 1962; Owusu-Ansah 1991). This is surprising given the significance of such protective devices to accounts of Western and Central Africa in European literature since the early inland explorations of Mungo Park (1840, 35) and Heinrich Barth (1857–1858, vol. 4, chapter 66). In order to move beyond these limitations, and to gain a better understanding of the formal properties of *layoyi*, an appendix of over one hundred pieces was collated from museum collections across the United Kingdom. From the museum sample analysis there emerged a particular unexpected result of relevance to this paper. In total, nearly one-third of the *layoyi*, this classic Islamic device, were associated with materials such as bone, iron, stone,

and wraps of herbs. The significance of this finding in light of the broader aims of this paper is that it indicates *layoyi* producers and owners had wanted syncretic charms: combining Muslim faith with protection from substances of symbolic meaning derived from indigenous religious frameworks (Insoll 2011b, 145–66).

Indigenous Medicine

Indigenous religion and the medicines which proceed from these cosmological structures can be problematic to define (Insoll 2011b, 146), particularly in the context of the diversity of practices apparent within migrant communities such as Madina. It is beyond the scope of this paper to offer a detailed explanation of the religious conceptions influencing each healers' therapeutic repertoire; however, an idea of the variety of spiritual medicines documented in 2010 amongst the participant group is provided in Table 9.2. As used here, indigenous religion denotes an overarching category that broadly describes a complex range of local and ethnic belief systems, distinct from Islamic or Christian orthodoxies (MacGaffey 1981, 243). Materials utilised are selected based on perceived efficacies in relation to animistic, totemistic and spirit-deity beliefs, whilst ritual activities include reference to specific environmental locales, blood sacrifice, and shrine-based performances. Delineating the diversities and connections apparent between each recorded medicine has been achieved through quantitative analysis of the qualitative field data, however by necessity this is provided in an abridged format here.

To summarise such a broad topic, focus is upon the most frequently recurring substances used in indigenous healing: ceramics, plant and tree substances, faunal remains, and stones/earths (see Oliver-Bever 1983; Nevadomsky 1988; Taylor and Fox 1992). The relevance of such materials is further explored in the closing case studies, where each are utilised in combination with Islamic literacy-based techniques in the production of heterogeneous syncretic medicines which reconcile both traditions. As one can see from Table 9.2 the range of substances incorporated within the spiritual medicines of Madina is varied,

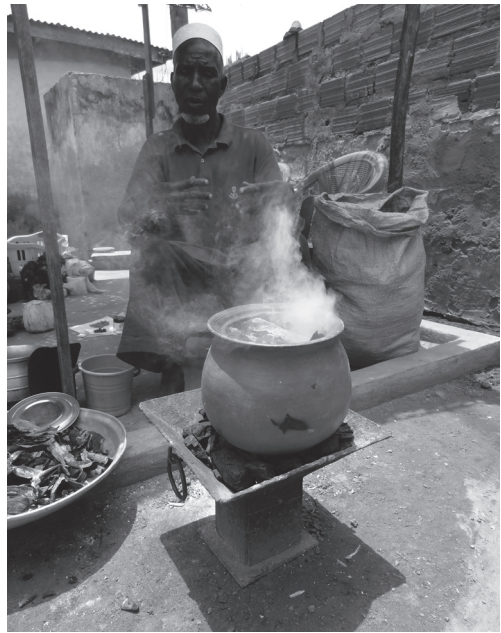


Figure 9.4. Chief Adamu performing *du'a* (prayer soliciting positive results), whilst charring the ingredients for a remedy to cure *sambo* (bad medicine). 'Cooking' the medicine took a little over five hours and it was left to thoroughly cool overnight before adding the final ingredient, a large quantity of gunpowder, the next morning (photo: Bryn Trevelyan James).

encompassing minerals, man-made ingredients, plants, and animal parts and products. In total, fifty-three unique spiritual medicines were identified during the first season of fieldwork (see Table 9.2). Of these, twenty-seven were attributed by the healers to knowledge solely based within the sphere of indigenous religion, seven were directly linked with orthodox Islamic practices, and nineteen were considered to combine both traditions; the products of syncretism. In general, syncretic medicines combined substances attributed powerful efficacy within indigenous religious belief with the *karfie* (strength) of one or more of the following Islamic elements: (i) infusion in *rubutu* water; (ii) performance of *du'a* (intercessory prayer); (iii) the writing of charms based on Qu'ranic verse.

Medicine no. and name	Source	Purpose summary	Religious basis
(1) Neolithic stone axe 'Haradu'	Adamu	Chronic headaches	Indigenous
(2) Sea stones	Adamu	Eye problems	Indigenous
(3) The ball of twine	Abdallah	Bad medicine/many uses	Indigenous
(4) <i>Vulunvu dogo</i>	Abdallah	Many uses	Indigenous
(5) Baobab tree bark	Abdallah	Protection against spirit forces	Indigenous
(6) Lucky powder	Abdallah	Luck	Indigenous
(7) Kafre mallam plant	Abdallah	Popularity/many uses	Syncretism
(8) Grinding stone	Abdallah	Protection against 'bad medicine'	Indigenous
(9) Fine black powder	Adamu	Stroke	Indigenous
(10) Antimony 'Tozali'	Baba	Seeing spiritually	Indigenous
(11) The Writing Stone 'Tonnyikari'	Ali	Protection against spirits	Syncretism
(12) Wolf bone	Yussif	Physical strength (fighting)	Syncretism
(13) Calabash	Yussif	Protecting finances	Islamic
(14) Lion bone	Omar	Physical strength (fighting)	Indigenous
(15) Goat	Abdallah	Positive spiritual results	Syncretism
(16) Guinea Fowl	Abdallah	To bring a person back	Syncretism
(17) The egg	Abdallah	Bad medicine/many uses	Syncretism
(18) Fragrance <i>Onalia</i>	Abdallah	Spiritual identity (communing with spirits)	Islamic
(19) Fragrance <i>Arouna</i>	Abdallah	Love	Islamic
(20) Fragrance <i>Bint el Sudan</i>	Abdallah	Love	Islamic
(21) Fragrance <i>Silver</i>	Abdallah	Popularity/many uses	Islamic
(22) The padlock	Abdallah	Closing court cases	Indigenous
(23) <i>Magani-maayo</i>	Baba	Protection against witches	Indigenous

Table 9.2. *Spiritual medicines.*

Medicine no. and name	Source	Purpose summary	Religious basis
(24) Spirit hair 'Gassi-aljenne'	Baba	Protection against spirits	Indigenous
(25) Parasite Tree 'Booro'	Ali	Protection against witches	Indigenous
(26) Tunfafia bark	Ali	Protection against bad medicine	Indigenous
(27) Kola nuts	Ali	Popularity	Indigenous
(28) Mamana seeds/burrs	Yussif	For quarreling couples	Indigenous
(29) Mamana seeds/burrs	Yussif	Cures bad medicine	Indigenous
(30) Sea/'water' stones	Yussif	Protection against spirits (compound)	Syncretism
(31) Hill/'earth' stones	Yussif	Protection against spirits/robbers (compound)	Syncretism
(32) Hill/'earth' stones	Yussif	Protection of child against spirits (compound)	Syncretism
(33) Darigana plant	Yussif	Protection against witches	Indigenous
(34) Chelkpela leaves	Yussif	Future reading	Indigenous
(35) Chelkpela seeds	Yussif	Contraception (female)	Syncretism
(36) <i>Tuale-wuta</i> Fire Medicine	Baba	Protection against spirits	Syncretism
(37) The Iron Allo 'Allo Karfie'	Baki	Many uses	Islamic
(38) Goyon-baya leaves	Baki	Bad medicine/many uses	Syncretism
(39) <i>Bekyi magani</i> Black medicine	Omar	Cures bad medicine	Indigenous
(40) Antiti	Baba	Protection against spirits	Syncretism
(41) Antiti	Baba	Female infertility	Syncretism
(42) Islamic written charm	Baba	Brings blessing	Islamic
(43) The black cross Tunfafia bark	Baba	Protection against witches/spirits	Indigenous
(44) Grinding stone	Abdallah	Purpose linked to acquisition location	Indigenous
(45) Nyuusu-nyuuga leaves	Abdallah	Protection against spirits	Indigenous
(46) Pins/needles	Abdallah	To cure chronic sickness	Syncretism
(47) <i>Karfie</i> Metal/Iron	Abdallah	Bad medicine/many uses	Indigenous
(48) The Ram's Horn	Abdallah	Many uses- talismanic protection	Indigenous
(49) Bagani Roots	Abdallah	Protection of child against witches	Syncretism
(50) Fragrance <i>Kunfaya-kun</i>	Abdallah	Bad medicine/many uses	Syncretism
(51) Seele seeds	Abdallah	Luck	Syncretism
(52) The <i>Kalo</i>	Baba	Personal shrine	Syncretism
(53) <i>Sambo-voogo</i>	Abdallah	Cures bad medicine	Indigenous

Table 9.2. continued.

Summary of Spiritual Medicine Sample Documented in Madina

In terms of the types of materials documented in individual spiritual medicines, plant substances were used in twenty-two, tree substances in eleven, faunal materials in thirteen, stones in eight, and metals in four. Eight medicines utilised none of these substances, instead being based upon empowerment of man-made resources: particularly fragrances integral to *du'a* performances. Typically a principle ingredient type was used, as found in forty-four cases, which served as the physical loci for the healer's ritual empowerment rites. Due to this healers generally followed the convention of providing medicine names based on the central material element, although some referred to the cures they knew based on purpose – for example (53) *sambo-voogo*, means 'cures bad medicine'. Nine medicines within the sample also combined two or more ingredient types, such as plant and faunal substances.

Preparation processes documented for the spiritual medicines included the following physical techniques: boiling/decoction, infusion (one substance in a liquid), concoction (several substances), charring, grinding, pounding and mixing; as well religious rites centred around blood sacrifice, Islamic literary elements, and other rituals of empowerment. Grinding ingredients was the most frequently specified preparation process in ten instances (in such cases drying would often have been a preparatory stage), followed by the interrelated process of mixing (9). The next most recurrently specified techniques were charring, infusion and decocting (eight instances each). In these processes, specialised forms of ceramic 'medicine pots' were used: sherds of blackened pot or small globular vessels with perforated bases for charring, and red-slipped pots with everted rims for 'cooking' or infusing a medicine. The other physical preparation processes applied were pounding (2) and concocting (1). Fifty-five other religious rites essential for ensuring the *karfie* (strength) of the substance prepared were also detailed. Islamic literary elements such as charm writing and *rubutu* were integral to seventeen of the medicines, whilst sacrifice or blood offerings, central to performances directed towards indigenous religious entities, were documented on seven occasions. Finally, perhaps the most characteristic feature distinguishing the production process of spiritual medicines from that of 'naturalistic', herbal cures was the frequency of various different forms of ritual empowerment, which were explicit, integral parts in thirty-three cases.

The mode of use for the spiritual medicines was similarly varied, and again combination of techniques was typical (Table 9.2). However, the characteristic remark healers made when explaining the application of individual medicines was that accompanying ritual performances must be observed by the client in order to activate the power of the medicine (24). These rites were specific to each case, although certain clear patterns reoccurred: prayers soliciting the desired result, acts of purification, and observation of taboos or proscriptions being the most common. The centrality of ritual performance throughout processes of spiritual healing was explained by *Mallam Baki* in relation to the concept of *warika-ruwa*, 'symbolic treatment'; the medicine acting as a 'mount' or metaphor for the efficacy of a higher power, such as Allah, to cure the patient. Typically clients would be warned that should they fail to correctly follow the necessary ritual performance they, rather than the healer, would be responsible for any lack of results (Waldram 2000, 609). The centrality of performance and ritual to

both production and application of the documented medicines should be stressed as, particularly from an archaeological perspective, the static nature of material residues is often given prominence over dynamic, fluid and active behaviours (Insoll 2009, 289).

As one may expect the typical physical mode of use was ingestion, by drinking or mixing with food (17), followed by external application as a poultice or by bathing (15). An additional bodily mode of application was incision (4), a liminal cutting technique penetrating the skins surface to infuse substances directly with the blood, which whilst a small part of the sample was evidently widespread as the formation of scar tissue for medicinal purposes visible on many community members attested (also see MacLean 1971, 78–79; Insoll 2011a, 190). Other modes of use included fumigation (8), typically to drive spirits from a compound. The burial of medicines in pots (3), a practice which has particularly archaeological visibility (e.g. Masquelier 2001, 219–21), and, finally, wearing (2) or keeping close (5) protective portable objects such as *layoyi* and personal shrines, are the forms of West African medicine best represented in museum collections.

Turning to the associated religiously structured rites frequently an intrinsic aspect of the process of spiritual medicine use, the healers recounted that in forty-three cases ritual performance practices were necessary. Often underpinning these activities, and thus shaping the physical emergences of traditional therapeutics, was ‘seeing spiritually’ (32), the ability of the *mai-jinya* to perceive the root cause of a patients’ unbalanced *lafia* emanating from the invisible spirit world. Whilst not as materially evident as more mechanical preparation processes, ‘seeing spiritually’ played a key role in influencing the form of medicine a patient received and frequently dictated the types and duration of prohibitions and regulations (21) it was necessary for the client and the healer to observe. In seven cases the client was also ritualistically involved in the preparation of their own medicine, typically being tasked to acquire a specific substance, or deposit the finished article at a special location, such as a cross roads (Last 2004, 723). Ideological associations between spiritual medicines and sacred locations within indigenous cosmologies were documented in eighteen cases, including locales such as hills, rivers, bush or forest and market places. This concept, the link between substances and the ‘spirits of a place’, be it a tree, river, or mountain, was especially characteristic of indigenous therapeutic practices, a point expanded upon in the following case studies.



Figure 9.5. Example of the wide range of healing materials important within indigenous religious ideologies found at the ‘Timber Market’ (photo: Bryn Trevelyan James).

The 'writing stone' or *tonnykari*

Overlapping systems of indigenous religious belief, with their shared pantheons of gods and deities, frame the material choices constituting individual therapies, particularly decisions to utilise substances connected to specific numinous entities. One example of such a medicine was the *tonnykari*, or 'writing stone' (see Table 9.2, 11), prepared jointly by the cousins Yussif and Ali, who incorporated indigenous religious practice with Islamic techniques. This combination reflected their linked but divergent biographies. Both were born in Benin of Kunari ancestry and were apprenticed with their fathers, before later moving to Accra where they came to live together in a joint compound, sharing a client base drawn from across the Madina community. Their healing roles and training however were distinct. Yussif, the younger of the two, was an Imam at the local mosque and specialised in Quranic healing, whilst Ali, older and more widely travelled, had a greater knowledge of herbs and indigenous healing techniques. The *tonnykari* reflected these distinctions in both its composition and conception of its curative power. Used for healing mentally troubled people, believed to be victims of malicious spirits, the central element is a large, smooth white stone collected from water. To prepare it the healers inscribed *rubutu* with burnt sugared ink on the stone, based on Quranic verse. It is then heated in the embers of a fire, and once hot the stone is taken from the ashes and allowed to cool in a bowl of water. Finally, the writing is washed into the water, which is then bottled and given to the patient to drink, morning and evening, for four days. Yussif explained the Islamic element of the medicine was a Quranic verse repeated seven times onto the surface of the stone, Surah XI:7:

And he it is Who created the heavens and the earth in six periods – and His dominion (extends) on the water – that he might manifest to you, which of you is best in action, and if you say, surely you shall be raised up after death, those who disbelieve would certainly say: This is nothing but clear magic.

(trans. Shakir 1988, 138)

Yussif stated that this verse, known as 'Hud', was powerful because it was symbolic of a well, inspiration of Allah rising up like water to wash away that which was unclear. However, Ali added that the stone itself was also fundamental to the medicine's power, and that the most important factor in its acquisition was that it must come from water – from the sea, a river, or a well. He described how he collected the stone personally during the drilling of a bore hole, and went on to explain that the local name for such stones, *tonnyikari*, means 'stones you hit together to get fire from'. Belief that stones have fire in them is a widespread belief which influences the use of lithics throughout West African medicinal practices (Parés 2006, 21). As Ali clarified, because this type of stone had fire in it, it was particularly suited to driving away *al-jene*, which, like Islamic *jinn*, are also conceptualised as being based around fire. Thus, the 'medicine' stone presents an interesting locus of elemental beliefs, derived from associations with animistic religious thought – the stone has fire *in* it, the stone *is* of water.

These indigenous concepts are further referenced through the technical stages of acquisition and preparation, both fire and water combined to 'cook' the medicine.

The *tonnyikari* must be collected from water. But it must be placed in the fire and then returned to water once again. Water is symbolic of life. There is a lot of energy perceived in water. Fire is powerful in its own way. It can bend metal. It can do untold harm. This is like the *al-jene*. But water is far more powerful than fire. Water can quench fire and extinguish it. Fire can never do the same to water. Even when you boil water it is not destroyed. The water becomes steam and flies away to become water again – Ali.

Interpretively, this medicine which Yussif called the ‘writing stone’ and Ali knew as *tonnyikari*, provides a metaphor for many of the healers’ activities in Madina. *Rubutu*, an Islamic technique based on the written power of the Word of God, is combined with indigenous animist beliefs in the connected properties of stone, fire, and water. Syncretism of belief is materialised in a number of ways; firstly, in the technical preparation choices – the decision to use the water-smoothed white stone, the decision to perform *rubutu* upon it – and secondly, in terms of the competing yet complimentary religious ideologies which underlie these material choices, providing dual sources for therapeutic efficacy. Taken as a whole, the interwoven symbolism expressed by the inscription on the surface of the stone, and the intrinsic spiritual properties believed to be in the stone itself, offer an example of the way in which the West African healers engaged with joined the threads of Islamic and African medicine. In such a way they provided treatments suiting the mixed cosmological beliefs of their community.

If the ‘writing stone’ is interpreted as a creative combination of *rubutu* techniques with the sacred properties of stone in indigenous religion, then the next case may be regarded as a more complex reconciliation. The following medicine, a form of portable secret shrine, binding powerful *al-jene* to the client, embodies the subtle tensions underlying the syncretism found throughout the Madina medical culture. Both the preparation and veneration of such an object break numerous Islamic prohibitions relating to blood sacrifice and idolatry, and yet Islamic charms were found to be central to the process of production

The *Kalo* of ‘Baba’ Yahaya: “The Combination Makes it Work”

On the closing weekend of the 2010 project, whilst visiting participants prior to departure, ‘Baba’ Yahaya was encountered deeply involved in the preparation of a medicinal object which he called, in Hausa, the *kalo* (see Table 9.2, 52). Its creation had been commissioned at considerable expense by a young government official from northern Ghana who sought ‘strong medicine for closing court cases, bringing continued success, and protection from the jealousies of *maayo* (witches).’ Baba had been hesitant to do the work, for although offered four hundred cedis (approximately £160), ‘the process is very tedious [...] taking around a week.’ However, after months of solicitation he had relented, acquiring what ingredients he could from the healers’ market in James Town, Accra, and sending to Bolga, in the far north of the country, for the rest. One of Madina’s most powerful *mai-jinya* (spirit-men), Baba had inherited control over supernatural entities from his grandfather following selection and ritual initiation in his youth. Although a Muslim, he attributed all his healing efficacy to *al-jene* (local spirits or ‘dwarves’), a belief which placed his practices outside the bounds



Figure 9.6. The *kalo* of 'Baba' Yahaya. A portable shrine object created through a union of Islamic *layoyi* and rituals binding indigenous spirits to material substances (photo: Bryn Trevelyan James).

of orthodox Islam, particularly in the case of works such as the *kalo* which reflected pre-Islamic rituals once far more wide-spread (Masquelier 2001, 217)

The object itself, photographed here just prior to covering, had at its core a donkey's tail, into which medicine previously stored in a ram's horn was inserted, bound up with white cloth. This is the '*kashin kalo*, or 'bone of the *kalo*'. After binding the cloth, four cowrie shells were tied 'mouth up' to the base of the shaft. Symbolic of prosperity and used in future reading, the cowries enhance powers of divination (Apoth and Gavua 2010, 230), their purpose to act as the *bakin-ido*, 'mouth of the eye'. To these materials, important within indigenous religious ideologies, was then added an unexpected Islamic element: four carefully wrapped *layoyi* papers, into each of which had been placed a pinch of black powder, Baba's *magani-maayo* (23), or 'witches medicine'.

One by one these four *layoyi* were tightly wound in four different colours of thread, each, as Baba explained, signifying the individual results the charm should bring. The first was wrapped in *fadi*, white, the colour of *lafia*, 'well-being'; to benefit the holder on their journey through life (Ryan 1976, 141). The second was wrapped in thread of *dja*, red, to protect against witchcraft and *sambo* (bad medicine), symbolised by blood and fire, whilst the third had thread of *batkyi*, black, to ward off evil spirits, associated with darkness and night (see Jacobson-Widding 1979). For the fourth and final charm Baba carefully entwined each of the coloured threads, wrapping the last *laya* in all three combined, thus directing the power of each element to work in totality, giving *karfie*, 'strength', to the power of the *kalo*. This combined thread of *fadi-dja-batkyi* was continued around the haft, tightly wrapping the *layoyi* above the cowrie shells.

With everything securely in place Baba then dripped liquid from a small fragrance bottle onto each of the four cowries and *layoyi*, the bottle branded with the name and likeness of *Mami Watta*, the Water Goddess (Van Stipriaan 2005, 323). At this point the *kalo* is at the stage seen in the accompanying image; the 'body' of the medicine has been crafted. Baba then began two separate coating processes, applying first a black and then a white resinous outer layer. Each was mixed in a small, shallow, black clay vessel called an *ekpese* pot, seen above, using, again, substances stored within the ram's

horn. A drying phase between each application ensured the medicine 'impregnated' the *kalo*, at the same time as obscuring its components. For the final part of the physical crafting Baba split the bark of the *kalego* tree into thin strips, rolled together on his leg to form a strong, well-rounded 'native twine'. This bark twin, wound around the haft of the *kalo*, symbolised the binding and tying of those who would oppose the holder, a common form of *sammu* (sorcery), and marked the completion of the various medicines combined within the shrine.

A shrine is 'dead', however, until it houses an *al-jene*, and so in the coming week Baba explained it was necessary for him to take the *kalo* into the bush to perform the empowering rites which marked the culmination of his efforts. A suitable tree has to be found, a hole dug amongst its roots, and the *kalo* buried to absorb the spirit residing there. Within a day the tree should begin to wither and the leaves fall as the *al-jene* departs, till on the fourth night Baba must return to reclaim the now living shrine. Before exhuming the *kalo* from the earth of the tree a final offering is made, the sacrifice of a black fowl, the blood of which should run over the *kalo*, into the roots and the soil, marking the transfusion of the *al-jene*. The addition of the blood, *jinni*, is seen as filling up the 'body' of the shrine, giving it *karfie* (strength) and life. With this final act the power of the object is made whole, ready to be transferred to the young government official. For the new keeper the first of many obligations will be to conceal the bloodied, earth-encrusted body of the *kalo* within a leather encasement described as the *fata*, or skin, prior to its ensconcing in a central but hidden compound location – the shrine room.

The *kalo* is contradictory in many ways: a mixed assemblage of indigenous spiritual substances comprising a 'body' or shrine into which is transferred, through ritual sacrifice, an *al-jene*. It is an object created by and for Muslims, who are expressly forbidden by Islamic religious laws to engage with neither spirits, nor idols, nor make offerings of blood to either. Yet despite the strong emphasis upon indigenous religious elements, Yahaya also chose to appropriate the power of Islamic techniques within the *kalo* by incorporating *layoyi*, thus placing the Word of God within the body of the piece. Importantly, this inclusion appeared to be no mere concession to Islamic sensibilities; rather, it represented an integral, fluid, and coherent aspect of the entire ritual crafting process. It is in this respect, in the weaving together of differing threads of religious belief to create a syncretic strand of practice, that the contradictory dialogues unified in such spiritual medicines point beyond the therapies themselves, resonating with symbolism and meanings structured by the heterogeneous medical culture which the *kalo* exemplifies. However, how do such practices in the present inform diachronic reflections upon residues of religious healing from the past?

Archaeological Implications

An overarching project aim has been to indicate possibilities concerning a body of religio-medical techniques, practices, and material substances which have been under-researched (Insoll 2011b, 146). Potential archaeological implications of the on-going investigation into contemporary indigenous healers' practices may be illustrated by comparing beliefs concerning the specific categories of materials documented, with

related features excavated at historic sites linked to West African indigenous medicine. A wide range of excavation reports detailing evidence of relevant healing practices have been identified for reanalysis, including works on shrines in northern Ghana by Insoll, Kankpeyeng, and MacLean (2008, 2009); publications by Africanist archaeologists such as Boachie-Ansah (1998), John Sutton's Zaria papers (1977), and Anne Haour (2003); and findings relating to Diaspora Africans in the Americas (Galke 2000; Gidwitz 2005).

In terms of the scope of this paper, it will suffice to briefly sketch the utility of such an approach by linking the description of the participants' substance-based spiritual medicines to Apoh and Gavua's (2010) archaeological excavations at the nineteenth century Katamansu *otutue* (shrine). This case study was selected for three reasons: firstly, the shrine, located on the Accra Plains, Ghana, has close spatial and historic connections to the contemporary study area (*ibid.*, 232–33); secondly, analysis of the shrines contents is presented in detail; and, thirdly, the authors' discussion of the remains excavated is well-supported by ethnographic examples (*ibid.*, 223–31). Consisting of two *otutui* (plural) of the Ga people, the assorted cultural materials found are described as 'the ritual accoutrements of an indigenous African religious priest' (*ibid.*, 223). They bear close resemblance to the 'paraphernalia of a 'medicine man's kit, namely, 'padlocks, keys, organic herbs, animals, brass and iron objects' (Field 1937, cited in Apoh and Gavua 2010, 223).

Katamansu shrine features	Comparable features from documented spiritual medicines (see Table 9.2)
Lithic materials (Apoh and Gavua 2010, 223–224) • Neolithic stone axe-heads • Smooth stone pebbles	(8), (44) Grinding stone [against bad medicine/many uses]; (11) writing stone/ <i>tonnyikari</i> [against spirits] (1) Neolithic stone axe/ <i>haradu</i> – lightening/'sky' stone [chronic headaches] (2), (30) Sea/'water' stones; (31), (32) Hill/'earth' stones [eye problems/protection against spirits]
Glass (<i>ibid.</i> , 224–226) • Perfumes	(18) <i>Onalia</i> [spiritual identity]; (19) <i>Arouna</i> [love]; (20) <i>Bint el Sudan</i> [love]; <i>Silver</i> [popularity/many uses]; (50) <i>Kunfaya-kun</i> [bad medicine/many uses]
Imported metal objects (<i>ibid.</i> , 225) • Padlock (brass) • Iron spikes (<i>ibid.</i> , 221)	(47) <i>Karfie</i> (metal/iron) [Bad medicine/many uses] (22) Padlock [closing court cases/bad medicine] (xx) <i>Appia</i> ('The Arrow') [bad medicine – for 'piercing' enemies]
Eggs (225–226)	(17) 'The egg' [bad medicine – the yolk & the white represent the duality of good and evil]
Local pottery vessels (<i>ibid.</i> , 226–228) • 'Ka' bowls	(52) The <i>Kalo</i> ['Ka' bowls used for ritual preparation of medicines]
Buried medicines (<i>ibid.</i> , 221)	(30), (31), (32) Buried medicines [protection against spirits]
Faunal remains (<i>ibid.</i> , 229–231) • Vertebrate bones	(15) Goat sacrifice [used for positive spiritual purposes; (16) Guinea fowl sacrifice [to bring a loved on back]
Cowry shells (<i>ibid.</i> , 230)	(52) The <i>Kalo</i> [Cowry shells used as divination tools, for the practice of <i>booka</i> , 'secrets']

Table 9.3. Selected examples of material elements excavated at Katamansu shrine, Accra Plains, compared to spiritual medicine documented in Madina, Accra (compiled from Apoh and Gavua 2010, 220–231).

From this description a number of immediate parallels between the sample of contemporary spiritual medicines and the excavated assemblage from the nineteenth century medicine men's shrine may be observed. An idea of the fuller interpretive connections linking the bodies of data can be seen in Table 9.3. Whilst the level of detail is necessarily concise, emphasis has been placed on connecting documented medical process incorporating similar categories of material, which may indicate interpretive perspectives in addition to those offered by Apoh and Gavua (2010). Of course, this brief exploration of the potential utility of consulting contemporary *mai-magani* (medicine men), concerning beliefs and performances associated with categories of material practice involved in 'traditional healing' contexts, should certainly not be regarded as offering definitive explanations about their meanings and usages. As the practitioners themselves are careful to emphasise, the purpose of every substance is multiple, dependent on the knowledge and aims of the individual crafter. What the exercise does demonstrate is that ethnographic information from ritual specialists is a valid means of accessing alternative interpretive perspectives on archaeological remains, and offers a productive direction for further research. Thus, including indigenous voices directly within analytical discourse fosters an approach which moves beyond the application of often culturally abstracted synchronic analogies. Such engagements may potentially access concepts situated more firmly within culturally relative values of local contemporary stake holders (Gavua 2012).

In summary, the continuities between assemblage compositions seen in Table 9.3 are significant not simply because it indicates potential time-depth of specific practices and beliefs. Rather, from an analytical perspective, these continuities emphasise the validity of Lane's (2006, 417) call to incorporate the voice of contemporary specialists in the interpretive process. Recent excavation reports such as Esterhuysen's (2008) study concerning evidence of indigenous medicine practices at the nineteenth century Historic Cave site, South Africa, benefit from the contextual depth and emic worldview accessible by including local informants directly in the discourse of analysis. In Esterhuysen's (2008, 468–69) case, working with a modern healer allowed him to establish which excavated substances and objects may have been part of the past medicine man's accoutrements and indicate their potential uses based upon comparisons to his own assemblage. The connections between the *otutue* sample and materials documented in Madina indicates a comparable level of continuity, suggesting future research with such informants may prove to be of similar value in enriching interpretive dialogues on healing in the past.

Conclusion

Medical substances and performances are essential to the maintenance of physical and social wellbeing and also serve as an ideological space for the mediation of group and individual identities, both for clients and the healers themselves. The medicines people seek, offer and provide speak of, and for, them. Therefore, as was indicated in Table 9.2, the materialisation of a medicine should be emphasised as an active, rather than static, process: the result of complex interrelationships between persons, substances, beliefs, ritual performances, and the skilled practices of crafting (Insoll 2009, 306). Almost

counter-intuitively this dynamic ritual fluidity, the weaving together of medicines from strands of power in both the natural environment and religious cosmologies, ensures continuity of the ideological traditions of the *mai-magani*, from the past to the present, by reconciling opposing elements within a shared medical culture.

Thus, in the case of spiritual medicines in Madina, healers act as creative agents, adapting elements from distinct practices to produce syncretic objects and therapies which objectively unify competing Islamic and indigenous systems. At the same time the *mai-magani* and the *mallam* are repositories and keepers of knowledge carefully transmitted as an inheritance between generations. From an archaeological perspective, then, the contemporary 'traditional' West African practitioner is at once an active, professional craftsman, a source of dynamism and change, and also a potential guide to the past, capable of offering an interpretive window on residues of activities they identify as their own. The possibilities for this dual role of the indigenous healer are perhaps best described in the words of Chief Adamu Zakaria:

What is the *mai-magani*? I am the potter and the pot. I am the legs and the head of the magane. From me new medicines proceed, and in me the medicines of my father are stored.

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10. A Note on the Ethnomedical Universe of the Asante, an Indigenous People in Ghana

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Introduction

Ailments, as universal problems, are frequent experiences in every human society. In the presence of this natural reality, societies and cultures develop answers to crucial health care issues and questions, and for them not to do so is, in fact, inconceivable. This need precipitates intellectual interpretations of health and infirmities, as well as philosophical and pragmatic techniques for dealing with the risk and uncertainties of ill-health. Naturally, such rationalisations and methods emanate from the specific cultural setting, prevailing endogenous conditions, and historical experiences of each society. The sickness, 'dis-ease', and malady that a person suffers, and the kind of health care that they would resort to, depend upon socio-cultural, psychological, and biological factors. Epidemiology, from a holistic viewpoint, should transcend the realm of the biological and allopathic.

The allopathic system, which is based on Western-engendered scientific methodology, suggests that natural events must be rationally explained in terms of specific empirical cause and effect categories; causation must be viewed as natural/biological in contrast to supernatural and metaphysical suppositions. In such a 'scientific' approach, substantiations in the system of belief must be reached through the observation of empirical data. Through the sketching and organisation of phenomena, analytical classificatory systems can be established and through the process of deduction, hypotheses are framed. Within these deductive processes, predictions are made about relationships between events. Such forecasts and ideas are proved or dismissed through further processes of inquiry and experimentation. However, this methodology, which is the backbone of the so-called 'scientific' or allopathic medicine, accepts that the outcomes of new experimentation can change the basic models and values. Therefore, if on the basis of specific empirical evidence, therapeutic measures are subject to modification and rectification in the face of the new facts to meet the health demands of people, then the trajectories of therapy within the context of 'scientific' medicine cannot be absolute. Conversely, the epidemiology of many indigenous societies promotes paradigms which utilise socio-cultural orientations, including the spiritual and metaphysical concepts, of the people it serves.

From historical and ethnographic viewpoints, this study explores the nature and philosophical keystones of the indigenous worldview of the cosmo-biological-cum-metaphysical oriented ethnomedical and health seeking behaviour of the Asante. The Asante are one of the African aboriginal groups that constitute Ghana in West Africa and the name can be contextualised to mean the people, their territory, and/or their language. Other orthographical constructs of Asante are *Asuantsi* and *Asiante*. The Anglicised forms are Ashanti and Ashantee (Christaller 1933, 427).

This paper is a small contribution to the wider studies of the history of medicine and medical anthropology, especially those of West Africa and Africa as a whole. By reviewing the Asante ethnomedical folkway and its historical and contemporary confluence with Western allopathic medical ways, this study, which fits into wider investigations of pluralistic medical systems in sub-Saharan Africa, provides a vista of understanding about the nature, and 'continuity' and 'change' dynamics, of that indigenous group's ethnomedicine.

While it is acknowledged that oral information obtained from fieldwork could have enhanced the research this paper focuses on information drawn from existing data including primary written sources. Consequently, this study serves as an overview that lays a foundation for later developments of review and fieldwork into the ethnomedicine of the Asante. In particular this paper seeks to bring together the broad spectrum of ongoing studies and extant literature about ethnomedicine within the contexts of history of medicine, cultural history, medical anthropology and sociology, and cultural studies (See, for example, Twumasi 1975; Janzen 1978; Warren 1978; Ademuwagun, *et al.* 1979; Evans-Anfom 1986; Twumasi and Warren 1986; Twumasi 1988; Vaughan 1991; Abdalla 1992; Feierman and Janzen 1992; Bierlich 1994; Sindiga, Nyaigotti-Chacha and Peter Kanunah 1995; Bierlich 1995; Addae 1996; Bierlich 1999; Konadu, 2007).

Consult the Spirits in the Morning, Drink Sarsaparilla in the Afternoon, and take Quinine in the Night: Gold Coast Ethnomedicine meets Western Allopathic Medicine

In the fifteenth century, the wealth of the territory that later became Ghana attracted the economic avarice and economic and political activities of certain European states, in part motivated by imperial ambition. At the beginning of the second half of the nineteenth century the area, which Europe knew as the Gold Coast, became a formal colony of England. This remained the case until outbreaks of local resistance and nationalism from the multi-ethnic indigenous sovereign polities defeated colonial powers in the territory in 1957. The new independent nation state that evolved called itself Ghana to recollect the fame of a Soninke empire, which existed c. AD 500–1200 (Boahen 1980, 3), in the *Bilad al Sudan* in West Africa. This zone refers to the savannah belt that spans the mouths of the Senegal and the Gambia rivers to the west of Lake Chad and the Nile to the east, and from the Sahara to the north and the forest belt to the south.

It is apparent that the indigenes of the Gold Coast, according to colonial historical records, had faced epidemiological challenges. For example, Pieter de Marees, c. 1602, reported that:

The diseases and plagues from which they suffer are: pox, the clap, gonorrhoea, worms, headache and hot fevers . . . Even though they catch some of these diseases, which are not without peril, they do not pay much heed to their injuries or illnesses and go around as if they are not suffering from any infirmities.

(de Marees 1987 [1602], 173)

The indigenous people contrived physiological innovations and cultural adaptations, including the quasi-reliance on primordial European strategies (de Marees 1987; Bosman 1967 [1704]), in their natural quest to combat diseases and subsist and prosper in their settled environment. Adapting to new medical needs and epidemiological challenges, some coastal indigenes relied, precariously, on European barbers, who were pseudo-surgeons based within European trading posts, for treatment of worm infection and exotic diseases which entered West Africa via the Atlantic trade (Crosby 1972, 122–23). The barbers often used sarsaparilla ointment, obtained from Dutch ships and traders, against the pox and gonorrhoea. The ointment was boiled in fresh water and the concoction drank as a panacea for the pox and similar diseases, and leg-attacking worms (de Marees 1987 [1602]).

Moreover, Willem Bosman, a Dutchman, who had spent about fourteen years on the Gold Coast, revealed in correspondences composed between early 1701 and mid 1702, that the barbers were charlatans who used bad medicine to endanger the lives of their clients (Bosman 1967 [1704], 106). However, Bosman, in these missives, which he published in Utrecht in 1704 as *Naauwkeurige Beschryving van de Guinese – Goud – Tand en Slavekust*, respected endogenous therapies. He emphasised the curative effect of some endogenic herbs and remedies: ‘the chief Medicaments here in use are . . . Limon [*sic*] or Lime juice, Malaget [*Afromomum melegueta*] . . . Cardamom, the Roots, Branches and Gumms [*sic*] of Trees, about thirty several sorts of green Herbs . . .’ Disclosing that the remedies were used frequently and successfully, he testified: ‘I have seen several of our country men cured by them when our own physicians were at a loss what to do’ (Bosman 1967 [1704], 224–25). He reported that locals who were shot, cut or wounded in wars used green plants for treatment. They boiled the herbs in water and soaked their wounds with the decoction, which proved efficacious in some cases, because of the ‘wonderful sanative virtue [*sic*]’ of the plants. However, some local therapies, Bosman claimed, were ineffective against venereal diseases, serious bleeding and internal haemorrhaging. Moreover, venereal distemper was difficult to cure, and sufferers who were near ‘our Fort fall in our Barber’s hands; who for a good large sum [*sic*] of money cure them’ (Bosman 1967 [1704], 110).

The Asante world of disease and health care also attracted the attention of European colonial chroniclers. For example, Henry Tedlie, who was a surgeon and part of a British diplomatic mission to *Asanteman* (Asante State) in 1817, recorded certain common diseases like syphilis, yaws, itch, ulcers, scald-heads, venereal diseases and strong pains in the stomach (Bowdich 1966 [1819]). There were domestic herbal preparations utilised as purgatives, to treat bone fractures, to cause abortions, to treat sprained ligaments, to relieve stomach pain, dysentery and diarrhoea, to neutralise symptoms of dyspepsia among pregnant women, and to treat boils, swellings, earache, coughs, eye pains, yaws and other ailments including venereal disease (Bowdich 1966 [1819],

371–77). For example, the cooked concoction of the bark of the ‘Tandoorue’ (*Tannuro*) tree and pepper was good for stomach pains and constipation; ‘Bissey’ (Kola) was chewed by the Asante to ‘prevent hunger and strengthen the stomach and bowels ...’ (Bowdich 1966 [1819], 371); the crushed leaves of ‘Anafranakoo,’ when applied to boils, inflammatory swellings and fractures, was a good remedy; the decoction of the leaf of the ‘Kattacaiben’ (*Kotodweben*) was good for pregnant women with uneasiness in the abdomen; the bark of the ‘Ocisseeree’ (*Sisire/Kokonisuo*) could stop purging in dysentery and diarrhoea and the ‘Tointinney’ (*Toantini*) herb, chewed with pepper, was a remedy for cough (Bowdich 1966 [1819], 371–77).

Nevertheless, European cultural intrusion, missionary activities, and colonial rule challenged and altered the praxis of indigenous therapy in the Gold Coast. By the beginning of the second half of the nineteenth century, there had been a significant development, and broadening of the frontiers, of European biomedical knowledge. This was beneficial to European powers, since it catered for tropical diseases and offered medical protection to Europeans in the tropics. The breakthroughs of Louis Pasteur, Robert Koch and Dmitri Ivanovsky in microbiology, bacteriology and virology respectively, in the last quarter of the nineteenth century, further validated the germ theory. The theory reformed Western medical knowledge and permitted the mechanistic conception of the body to dominate medical philosophy. This new approach that stimulated allopathic medical practices was endorsed and steadily popularised in the Gold Coast, including Asante, by European missionaries, imperial agents, and the British colonial administration in particular.

The British established infirmaries, but these were mainly restricted to government residential areas in the urban centres (Agbodeka 1972), and some plantations and mining centres in the colony, including Asante. Most locals, including countless in Asante, therefore, survived on ethnomedical services. Some Asante further relied on the Arabo-Islamic (Koranic) medical and health care traditions, which were part of the Islamic culture that penetrated Asante. Doses of Islamic culture had earlier reached the northern states of the Gold Coast because of their mercantile and cultural connection to the ancient Trans-Saharan Trade network which connected West Africa to the Arabo-Islamic world (Anquandah 1982, 80–84). By the mid-eighteenth century, Islamic culture had permeated the Asante society (Anquandah 1982, 111) because of the diplomatic, commercial and political relations between *Asanteman* and the northern states of the Gold Coast.

Determined to expand medical infrastructure to promote allopathic medical techniques among the colonised population, the colonial administration, under the governorship of Sir Gordon Guggisberg, built the Korle-Bu Hospital in 1923 in the colonial capital of Accra (Agbodeka 1972). Other hospitals for the locals were subsequently built, but still predominantly in the urban centres (Agbodeka 1972). This colonial period marked the formal beginning and steady use of the services of doctors (physicians and surgeons), nurses, pharmacists and other allopathic health care specialists, in health care establishments like hospitals and clinics. The period ushered in a sustained use of diagnostic methods like clinical examination and x-rays, and disease preventive and curative methods such as vaccinations, factory manufactured drugs and surgical operations.

Since 1957, when British colonial rule ended in the Gold Coast, the pattern of the colonial formal allopathic health services delivery has been reproduced and expanded by successive governments whose official policy has been the extension of medical facilities, through the collaborative efforts and initiatives of the public and private sectors of entrepreneurship, to meet the growing needs of the people. The establishment of more health centres and training of health personnel have persisted.

It must be noted that missionaries and agents of the colonial regime had declared African healers, their concepts and practices as illegitimate, non-scientific, unchristian, and backward. Consequently, Western biomedicine was given a hegemonic position in the Gold Coast. Interestingly, the same denigrated indigenous knowledge (I. K.) therapy was employed by an African herbalist in the 1830s to save the life of the Basel missionary Andreas Riis in his struggle with malaria. Malaria had killed his colleagues, Peter Jager and Friedrich Heinze, the latter of whom was a medical doctor from Saxony (Schweizer 2000, 20). Was the practice that Riis benefitted from scientific and progressive? According to Barnard and Spencer, I. K. systems are analogous to scientific understanding within local cultures. This implies that I. K. is indeed systematic in a similar way to 'modern' (Western) scientific methods (Barnard and Spencer 2005, 609).

The above assertion should not be taken as an attempt of this essay to embark on a misguided quest of identifying specific African beliefs and finding their equivalent in Western thought. This study avoids such a comparison as it investigates the Asante of *Asanteman* specifically. However, it is noteworthy that in recent years, a strong case has been made for sustainable development projects, socio-economic growth, and health care delivery of local communities to be compatible with, and also informed by, epistemic, axiological and technological constructs and concepts derived from I. K. systems like those of the Asante.

Asanteman: the Genesis of a People and a Nation

Asante is an ancillary *Oman* of the Akan. *Oman* is the Akan equivalent of indigenous state/community. The plural is *aman*. When shortened, *oman* becomes 'man,' hence *Asanteman*. The Akan originally occupied one of Ghana's varied major vegetation zones, which geographically demarcate the ethnic groups. The Akan, the largest ethnies, predominantly occupies the tropical rainforest, although a few Akan sub-ethnic groups, including the Fante, occupy the southern coastal shrub.

The Asante are mainly of forest origin. The forest, which has traditionally had a multi-purpose value to the Akan, is known as *kwae* in Asante. The forest Akan utilised I. K. to domesticate the forest and made it the backbone of their pharmacopoeia, food, clothing, and shelter (Owusu and Kwarteng 2010, 87). I. K., according to Kuupole and Botchway (2010, 1–15), is local knowledge unique to a particular society which is rooted, integral, natural and/or innate to that society. The Asante evolved in the early years of the second part of the seventeenth century as an organised confederacy comprising a small constellation of related minor matrilineal chief-ruled *aman*.

Mary Owusu, in *Prempeh II and the Making of Modern Asante*, posits that it is difficult to trace the genesis of the Asante because their indigenous ancient history is unwritten

but steeped in oral tradition and myth (2009, 1). She stated that the common answer that is likely to come from an Asante when the question about origins is posed is: 'We [Asante] came out of a hole in the ground at Asumegya Asantemanso (a place in Ghana) *the Eden of the Asante* many years ago' (Owusu 2009, 1, my emphasis). She, however, suggests that the allegorical legend can be understood from the perspectives of the individual *aman* that constituted *Asanteman*. The Asante *Amantuo Nson* (seven premier states) namely: Kumase, Mampon, Bekwai, Dwaben, Kokofu, Nsuta and Kumawu, which pioneered the formation of the confederacy, with Kumase as its capital, may have created the myth in their quest to necessarily forget, and make future generations forget, their individual past statuses and histories for the greater unity of the Asante nation (Owusu 2009). The myth, symbolically, marked a rebirth of the states under a new leadership, and signified their '... new birth and a new emergence ... from ... the bowels of Mother Earth herself who gave life to humanity' (Owusu 2009, 2).

The *raison d'être* for the early union among the states was the shared desire to overcome the imperial hegemony of Denkyera – a powerful chiefdom in pre-colonial Ghana. Thus an etymology of the name Asante, a designation which evolved from the agglutination of the Akan Twi radices *Asa/Esa* (war) and *Nti* (reason or because), suggests that the states, which were vassals of Denkyera, became integrated 'because of a war' to liberate themselves. Together, they vanquished Denkyera. The confederacy, which assimilated other communities, grew in size to become *Asanteman* and flouted the conventional understanding that alliances collapse when their common enemy is overpowered. The Asante realm used diplomacy, intimidation, coercion and straightforward conquest to dominate its neighbours during the first century of the Union (Owusu 2009). Asante, guided by its leaders, engineered a national and cultural ideology, identity and image, and a complex way of life, which emanated intricate socio-political aspects and useful features. By the end of the eighteenth century, it had become a supreme chiefdom in West Africa (Boahen 1980, 70).

By the late nineteenth century, the indigenous world of Asante had developed a sophisticated bureaucratic government, tiered in structure, and in the imperial mould. At the apex of the confederacy was the *Asantehene* (Paramount Chief of the Union). He was the custodian and occupant of the revered *Sikadwa Kofi* (the legendary Golden Stool Kofi of the Asante). Legend has it that the Stool was generated by the *Abosom* (deities) and *Nananom* (spiritual ancestors, singular *ana* or *nana*) of Asante, and magically conjured from the sky by Okomfo Anokye, the first *Okomfopanyin* (high priest) of Asante, to be the emblem of political authority and to be evidence of the unique and sacred ordination of the *Asantehene* (Shokpeka 2005; Agyeman 2009). Supporting the *Asantehene* to govern and to direct the socio-political affairs of Asante was the *Asanteman Hyiamu* (Asante Council). The council was constituted of the *Amanhene* (paramount chiefs) of the member states of the confederacy, and the *Asantehene* was their *primus inter pares*. The *Amanhene* also, with the help of councils made up of the correct representatives (chiefs) of districts within the constituent states, governed their domains (Busia 1951; Casely-Hayford 1905).

The *Asantehene*, *Amanhene*, town chiefs, village chiefs, and citizens in the states within the Asante polity owed allegiance to the nonphysical political power within the Golden Stool. An Asante can therefore be defined as 'any person who owes allegiance

to the Golden Stool [and its occupant]' (Agyeman 2009, 152). The power in the Golden Stool is drawn from its position as coming from deities and ancestors, where ancestors have a specific meaning. The Asante believe in life after death, and ancestors are the 'special' dead; men and women who have physically died and have moved on to live in the spiritual world where they continue to be active members of the lives of their living relatives. The emphasis on 'special' is to show that not all dead people become ancestors. Instead the 'special' dead are those who led exemplary lives when they were alive. The living continue to venerate and pray to them for their spiritual blessings. The Asante believe that these ancestors can reincarnate; they are born, as children, into their societies to help with the development of society and the perpetuation of life.

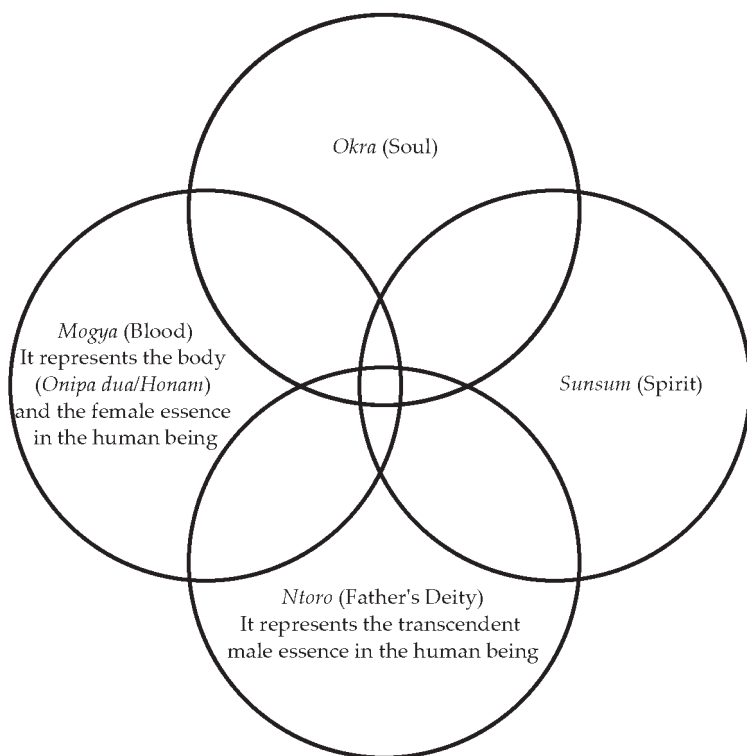
The imperial ambitions of *Asanteman* threatened smaller African polities, including the coastal Fante and Ga states, and European powers, especially the British. The British, determined to politically and culturally dominate *Asanteman*, succeeded, after several failures, in capturing Kumase, the Asante capital, in 1898. The British crushed a subsequent rebellion – the Yaa Asantewaa War – and, in 1901, declared *Asanteman* as a colony of Great Britain (Boahen 2003). Interestingly, the proverbial anti-colonialism stance and cultural pride of *Asanteman* have led the Asante to traditionally affirm that 'the British did not conquer us.' Nevertheless, the military defeat and colonisation of Asante marked the genesis of a full exercise of British political authority over that ethnies and a greater intrusion of Western and English cultural concepts and motifs, including medical and health care practices, into the socio-cultural fabric of the Asante.

The Human Being is, Therefore Diseases are: the Conception of the Human Being within Asante Worldview

Asante society contained and developed a complex epidemiological worldview. This worldview contained practices and beliefs, intricate philosophical dimensions, and valuable pragmatic operations. As indicated, the indigenous people of the Gold Coast were familiar with a variety of maladies and treatments. Their worldview generally identified the human being as a composite of body, soul (conscience), and spiritual element (Opoku 1978; Sarpong 1974, 37–38) and their understanding of ill-health and remedies covered these dimensions. In their worldview, the external and internal world of a human being shared the same principles, and good health required equilibrium of the two. Therefore, the concept of perfect health, which the Akan referred to as *apomuden*, was a harmonised combination of bio-physiological principles, body channels, digestive and excretory processes, mental faculties, senses and the (spiritual) self. Consequently, the actual attitude of the Asante to human health and conception of illness were, and are, grounded in the aboriginal philosophy that the human being (*onipa*) is an intimate conjunction of biological/material/physical and immaterial/spiritual elements/forces (Danquah 1968; Wiredu 1997, 48–51).

Onipa is classified according to four types of indivisible constitution (Busia 1954; Agyeman 1994, 17–18). The four are: *okra* (soul), *sunsum* (spirit), *mogya* (blood), and *ntoro* (father's deity). *Mogya*, which is tangible and represents the biological figure/body (*onipa dua/honam*) is also the female essence in *onipa* because it is obtained from the

Figure 10.1. A diagram showing the Akan and Asante conception of the various interlinked physical and spiritual parts that constitute the *onipa* (human being).



mother – the female part of a person's parentage. *Mogyia*, therefore, relates a person to the mother. On the other hand, *Ntoro* comes from the male part of a person's parentage and is the transcendent male essence in *onipa* (Gyekye 1995, 85–102). *Onipa* has *apomuden* if these constituents are well balanced. To prevent or treat illnesses or restore good health, harmony between these facets must be guaranteed and/or re-established (see Fig. 10.1)

The physical and perishable *honam/onipa dua* includes anatomical parts like organs and tissues, which have their functions and instincts (Opoku 1978, 100–23). The immaterial and immortal part comprises *okra*, *sunsum* and *ntoro*. *Okra* is given by *Onyame*, the Ultimate Reality who created the heavens and earth (Wiredu 1997, 41–45). Every visible and invisible thing owes its existence to *Onyame* (Wiredu 1998, 30–32). *Okra* is god-like and cannot be corrupted by sin or evil committed by the person. As the guardian spirit, protector, conscience and advisor of *onipa*, *okra* can be *kra pa* (favourable soul) or *kra biri* (unlucky soul). *Onipa* cannot survive on earth without it. The *onipa dua* expires when the *okra* departs to *Onyame* (Meyerowitz 1951, 24–31; Agyeman 1994, 56–60).

Sunsum is a vital personality spirit which originates from the father and links a person to him. It formulates a person's character, disposition, mental fortitude and intelligence (Agyeman 1994). Perceived as a specific astral double, which expresses the intimate essences of the ego in the individual being, it manifests in dreams. It can be attacked by malevolent spirits, witchcraft, and sorcery, and when it is defeated it becomes frail. Consequently, the *onipa dua* becomes fragile and can suffer from different illnesses. A

strong *sunsum* protects an *onipa* from spiritual attacks and the maladies that manifest physically in the *onipa dua*. When the *onipa dua* perishes the *sunsum* goes to the spiritual world and, depending on the kind of life it led on earth when it occupied a body, becomes an ancestor or an *osaman* (a roaming spirit or ghost). A *sunsum* which led a virtuous and morally upright life finds solace in the world of the ancestors and can choose to reincarnate. One which led an evil and sinful life and/or did not die a natural death or die in the service of humanity becomes an *osaman* and can also reincarnate to fulfil an unfulfilled destiny.

The *ntoro* element demonstrates a father's link with a child through the father's sperm. It is associated with a presiding and protector male totemic spirit which is connected to either a river, lake and sea deity. People of the same *ntoro* group consider themselves as siblings (Opoku 1978). When the *onipa dua* dies the *ntoro* spirit joins its deity. It reincarnates again through any male of the same *ntoro* lineage.

Onipa is born into a family (*abusua*) and society (*kro*); therefore, he/she is a social person, as well as/not just an individual being. Membership of *onipa* within society is more emphasised than his/her individuality. The human 'being-ness' of *onipa* is because he/she belongs to a social network of other fellow human beings and the spiritual powers – deities, ancestors and *Onyame* – in the physical and spiritual worlds respectively (Opoku 1978; Wiredu 1997, 48–51; Gyekye 1995; Busia 1954). *Onipa* is, therefore, required to obey the rules of the community and spiritual powers for peace and harmony to prevail in him/her and society. Therefore, the entire world of *onipa*, which affects his/her health, was and is conceived as a complex of terrestrial/earthbound (physical/psychic) life and super-terrestrial (spiritual/immaterial) or past and future life zones.

Indigenous Medical Lifeways of Asante: a Case of Continuity and Change

The indigenous ethnies of the Gold Coast generally utilised a wide array of endogenous flora, fauna and minerals as resources, in their *Materia Medica*, for therapy within their ethnomedical pursuits. The I. K. about the natural resources was not based on the application of Western/non-African categories and approaches such as chemistry and pharmacology. It was based on intricate endogenous systems and sciences of biological and spiritual properties of natural materials, which provided knowledge about aspects such as classification, parts used, procedures of refinement and modification, contraindications, effects of physiological, psychological and spiritual systems, impact on the tissue and organs, and therapeutic qualities of drugs. Although functional links can be contrived between that indigenous system and Western biomedical science, the task of establishing a strong connection between the two is complex because of the lack of a well-accepted methodology to support thorough cross-cultural studies.

Various scientific and technological traditions have developed different categories for studying the same phenomena and diseases. For example, if the nutritional properties of food substances were to be described in the context of contemporary Western biochemistry, the description would be done in terms of proteins, carbohydrates, minerals and fats. Plants with medicinal properties would be described in terms of

active ingredients. Additionally, scientific enquiry and verification would be limited to the use of the five senses namely: smell, taste, hearing, touch and sight.

However, within the Asante worldview, where perceptions about life and the human being, and viewpoints and practices about medicine and health issues were originally encapsulated and passed on in traditions shrouded in superstitions, rituals, taboos and folklore, different categories were used and the analytical methods were not limited to the five senses. As a tradition that incorporated knowledge about definite medical procedures and the concept of some religious/spiritual power involving forces beyond human comprehension which affected human health, complete awareness was sought at a level of perception by which the observer both reached out and perceived within. In other words the observer both grasped a health problem in a person – the observed – from the physical level through the use of the bodily senses and empathy, and the metaphysical level through spiritual discernment (clairvoyance) and responsiveness. This established a subjective flow between the observer and the observed. Consequently, the senses were complemented with the mind and spirit, preferably free of the prejudices of anger, greed, jealousy, lust, intoxication, and delusion. Thus, within the Asante ethnomedical context, the five senses were essential to decipher the physical and tangible world and naturally understand good and bad health. The mind and spirit enabled an exploratory perception that oscillated the material and immaterial realms of consciousness and provided an understanding of the physical, psychological and spiritual dimensions of medicine and good and bad health.

Vestiges of the philosophical concepts and pragmatic practices, conjoined within this ancient understanding of the causes and curing of diseases, persist among the Asante even though many have become medically pluralistic. This is because, when the need arises, they employ both Western allopathic medicine and indigenous ethnomedical concepts and methods in their health seeking behaviour. Adherents of the endogenous path and those of the exogenous way continue to co-exist, contemporaneously, in a mutually independent context with little prospect of one displacing the other.

The ethnomedicine of the Asante has been historically enduring and intellectually stimulating. What then are the nature and philosophical underpinnings of that tradition that was established by progenitors of that ethnies to provide health care for themselves and posterity? The assimilation of the exogenous tradition, which conceptualised that bodily illnesses are caused by parasitic organisms such as bacteria and viruses, was produced from the Asante interaction with European explorers and experience with British colonialism. The Asante ethnomedical theory is devoid of any indigenous awareness of a minute, imperceptible organism or germ or virus as an ailment transporter. Furthermore, deficiencies in nutrients like protein and vitamins, and other determined causes of disease that allopathic medicine reveals, are not present. Nonetheless, that health care system, infused with anthropological, bio-physiological, spiritual, and psychological dimensions, seeks the promotion of holistic healing. The presence of these dimensions – a product of the endogenous conviction that mind and body, life and death, individual and society, spirit and matter are all interconnected – makes methods and therapies for dealing with ill-health encompass natural, spiritual and metaphysical, and psychosomatic aspects.

Accordingly, the Asante rationalises that illness is a natural repercussion to persons

who violate any law of hygiene or accepted way of social conduct. This view also recognises two major principles for the causation of ill-health namely: (i) external dirt/accumulated waste (*efi*) in the human body attributable to indigestion or eating of certain kinds of food, and (ii) breach and disharmony in the relationship between a person and the spirit world, and therefore society, which brings pain, anxiety and worry to a person. In the case of the latter: confessions to wrong doing in society; performance of acts of penance such as offerings to pacify the spirit world and the self; consumption of holy herbal and mineral medicine; execution of ritual purification rites like the taking of holy ablutions, prepared from water and local herbs like *edwono*, *adwera* and *nyenya*; and enactment of other *nyankomadie* (ritual acts) prescribed and supervised by specialist health experts, would be some of the practices which the patient would implement to create balance between him/her and the spirit world. The patient also performs such practices to overcome the psycho-somatic aspects of his/her ill-health conditions, and to receive a healing whose psycho-therapeutic value is undeniable.

The comprehension of the natural cause of diseases (*nyarewa*) made the Asante develop the use of herbs and other physical medical procedures to provide remedies (*aduro*) and medicine (*dufa*). These were prepared as herbal concoctions (*odudo*), pastes, and compositions formed into balls (*dufuaw*) to work as stimulants, emetics, laxatives, antibiotics, and contraceptives. Others were therapeutic formulas produced from various natural sources like animal parts, water, and minerals. One example is *boto*, a medicinal powder, often kept in a gourd. *Boto* is rubbed into incisions made on the skin so that its medicinal properties would enter the blood stream and cure or prevent a malady or maladies. Mechanical techniques such as sweat baths, massaging of sore body parts with herbs, and isolation of patients during epidemics were also employed.

Characteristically, Asante ethnomedicine did not operate at the 'classical' but rather at the 'folk' system level. In other words, it was not characterised by a corpus of ancient literary texts and preserved manuscripts, containing codified systems and theories that encompassed knowledge of life, health, disease of humans, animals and plants, which were used by institutionally trained practitioners. Asante was an oral society and so its ethnomedical concepts, which were anchored on beliefs and operated praxis at the folk system level, were transmitted orally through time.

The folk tradition that has persisted is richly diverse. It operates on two domains namely: formal and popular. The theoretical and practical knowledge in the former is less diffused. Acquired through specialised training the knowledge is controlled and implemented by adept specialists. Some are general physician/doctor-priest/priestesses (*akomfo*), who are custodians and spokespersons of the community, personal deities and ancestors. Such experts employ supernatural means to heal. Others are general herbalist-pharmacist physicians (*adunsifo*) who are capable of dealing with different health problems. Other *adunsifo* are specialised in definite domains and work with specific diseases, bone setting, poisoning treatment or birth attendance.

The practitioners in the formal domain bequeath their knowledge to younger successors who they choose or are called by the deities through spirit possession or dreams. The successors are selected on ethical criteria, which include qualities such as patience, strong faith in *Onyame*, respect for the deities and ancestors, courage and love of humankind. Some may argue that this ethical screening is too esoteric. But how

could this explain the fact that at the beginning of the twenty-first century, the Asante continue to have a large number of carriers of the oral health traditions throughout Ghana? It is because that indigenous knowledge is still alive, accessible, and useful and so many people continue to sincerely search for it, possess it, and use it to help themselves and their society at large.

The folk tradition also includes knowledge and beliefs regarding the relationship between food and health, hygiene and health, and physical acts and spiritual rites of a preventive and curative nature as well as the use of home remedies obtained from the vegetable, animal and mineral worlds for common ailments. The application of such domestic natural remedies, within this system, is usually accompanied with benedictions, certain rituals and sacred symbols, to invoke the benevolent assistance of the spiritual forces in nature and the spirit essence in the plant, animal, or mineral providing the medicinal substance needed to prevent and/or cure an illness, and guarantee and/or restore good health. This tradition falls in the popular domain, whose aspect of health care reflects the amateur and non-specialist treatment activities that are customarily started at the inception of a disease. The knowledge therein is popularised, and patients and advisors often share similar epidemiological assumptions and definitions.

The major setting of this system is the family where most diseases are detected and treated. The general information which elders have about the anatomic functions of the *onipa dua*, medicinal herbs and their spiritual therapeutic properties, and the causes of different diseases and their treatment, animates the system in the popular domain. For example there is the popular knowledge that accumulated waste in the body, produced by natural disorders like indigestion or personal blunders like the eating of certain foods, especially taboo foods (*akyiwadie*), can cause headaches, waist pains, piles etc. The general cleansing remedy for such a disorder, which would be recommended to patients by health advisors who, normally, are knowledgeable and experienced adult members of families or society, would be herbal laxatives, emetics and enemas, with a common herb like *anumanum/nunum*, and sweat baths. Health mentors may also include a person with long experience of certain diseases and their treatments, or a woman who has raised many children and so is conversant with issues related to pregnancy and labour. Such people can rely on their knowledge and counsel others who need health care information.

The health care universe of Asante combined scientific, naturalist, magical and religious practices to produce holistic healing contexts and therapeutic outcomes. The veritable institutionally trained experts who may also be adepts in magic art (*suman ade*), exorcism, and healing (*ayaresa*) possessed an assortment of resources in their medical practices. These included the power of words and prayerful speech (*apaye*), the efficacy of ancient arcane ritual motions, medicinal herbs, and the trust invested in *asumane* (magical amulets and talismanic pendants) of all sorts. Priests and priestesses, in hallowed sanctuaries of deities, and herbalists, who venerated the spiritual essences and medicinal properties in plants and the spiritual guidance of ancestors and deities, all specialised in the administration of therapeutic cures under the ultimate patronage of *Onyame*.

The philosophical underpinnings of the two significant principles responsible for ill-health in *onipa* were: (i) failure of *onipa*, a composite of organic, spiritual and divine

energies, to harmonise with the laws of hygiene and the spirit world, (ii) failure to recognise the initial act responsible for the disturbance of established balance between a person his/her physical and transcendental environment, and (iii) inability and lateness of this initial force to respond to any act of reparation, and delay in making appropriate diagnosis leading to the illness taking an irreversible turn. Illness was therefore a material reflection of a perpetual, collective struggle between health giving forces and contaminated ones. Consequently, within the domains of the popular and formal systems of the folk tradition diagnosing and treatment, illness and cure were perceived as an interplay of cosmic, social and biological relationships within a collective schema in which the entire culture, morality, religion and spirituality of the society were categorised, and where a spectrum of ritual practices of metaphysical and spiritual values and natural remedies were employed to serve *onipa* who was simultaneously human and divine/sacred. That was why the endogenous conceptions about health, ailment prevention, and the art of curing and healing represented a total cosmic science. The practitioners of this science, believing firmly in the existence of sacred dimensions and zones beyond the real, deployed in their art of holistic health care an array of objects, practices and strategies to aid that effort of transcendence. These included: drugs, water, oils, leaves, roots, herbs, ritual and sacred ceremonies, the development of mental power, magic, ancestral myths, religion, and natural sciences, all of which contributed to the practice of the curative and preventive aspects of Asante ethnomedicine.

Physical vestiges of this accumulation of ethnomedical knowledge are still prevalent among the Asante. The indigenous understanding about precise anatomical information, therapies derived from flora, fauna and minerals, invocations of 'magical' and psychic energies, utilisation of incantatory therapies based on the envisaged therapeutic sonic influences of the spoken word, which is of divine origin, and professional specialization in the treatment of illnesses, are prevailing at the start of the twenty-first century. Nevertheless, the general corpus of indigenous ethnomedical traditions of Ghana has been eroding gradually since the colonial era. This deterioration has had a chiefly adverse impact on access to local health care, which is of national relevance. The erosion has been quite apparent, yet the causes are not clear. It would be too simplistic to posit that endogenous traditions are fading because they have proven ineffectual in satisfying past and present epidemiological needs. The reasons for the erosion should be examined from the historical, political, economic and social circumstances rather than medical. For example, the natural resources utilised by endogenous medicine are endangered due to the extensive damage to ecological complexes, and in particular cases, because of over harvesting for commercial purposes (Owusu and Kwarteng 2010, 94–96).

Wild and domestic plants and animals, and minerals in Ghana are still endowed with healing properties and the local knowledge of such elements and spiritual healing practices is still profound. Concurrently, there is a quick resurgence of interest in natural medicine and ethnomedicine throughout the world because it is apparent that they have potential. This paper opines that Ghana's policy makers in government can take some pragmatic steps to promote and effectively sustain ethnomedicine. This essay suggests that support must be forthcoming for sustainable research into those traditions undertaken by academics, perhaps to codify some of the techniques, and popularise and disseminate their potentials through the formal and informal civic educational

systems. Secondly, practical measures, such as committing a considerable percentage of the annual health budgets to protect and conserve the endangered genetic resources and habitats, and codification of endogenous systems of medicine, should be taken by the national policy formulators and executors to safeguard Ghana's essential corpus of ethnomedicine.

Conclusion

In this paper, the nature of Asante ethnomedicine and the significant philosophical underpinnings of that medical lifeway, which are inspired by the group's indigenous belief system and world vision, have been presented. This has also been accompanied by a discussion about the nature of the so-called scientific medicine and ethnomedicine derived from I. K. and the differences between the two. It has come out of the discussion that each of the two has distinctive scientific knowledge and foundations.

Furthermore, historical accounts about interesting aspects of the situation of ethnomedicine in pre-colonial and colonial Gold Coast, the evolution of *Asanteman*, the introduction of Western allopathic medicine into the Gold Coast, and the development of continuity and change within Asante ethnomedicine have been presented. It has been indicated that the Asante conception of diseases and how maladies are cured derive from that group's aboriginal conception of the human being as both a physical and spiritual entity. It has also been shown that the concept of perfect health, known to the Asante as *apomuden*, is thus a harmonised combination of bio-physiological principles, body channels, digestive and excretory processes, mental faculties, senses and the (spiritual) self. Therefore, within an Asante model of indigenous metaphysical and physical scientific knowledge, all diseases are perceived and approached from both the physical and spiritual dimensions.

This investigation has shown that the concept of microorganisms as causative agents of diseases is lacking in Asante ethnomedical knowledge. Nevertheless, among other beliefs that suggest that diseases can be caused by physical factors, the idea of the lack of hygiene as a cause of disease to the human body is present in Asante ethnomedicine. Consequently, the Asante has a *Materia Medica* which employs a wide array of physical properties obtained from the animal, plant and mineral worlds to prepare medicine for the healing of diseases. The application of these natural medicines is mostly accompanied by certain prayers and supplicatory acts to invoke the spiritual power and healing assistance of spiritual entities such as *Onyame*, to make the therapy effective and holistic. The study has revealed that Asante society contained and developed a complex epidemiological worldview which had practices and beliefs that had intricate philosophical dimensions and contained pragmatic procedures.

Asante ethnomedicine is concurrently natural/biomedical, ritualistic, and spiritual/metaphysical because it serves the multidimensional *onipa* within his/her total personal, family, mental, social, cultural, historical, astral, and cosmic environments. The group's epidemiological worldview is not another 'backward' cultural manifestation of an indigenous people, because it is rooted in I. K. which is analogous to scientific knowledge. The bulk of that ancient wisdom is, significantly, an immense treasure

house of science and know-how, encapsulating ethos rooted in the 'Black' African cosmo-biological-cum-spiritual *Weltanschauung*, which has manifested in the African continent and diaspora of the recent and remote past. The study of medicine and its history will benefit greatly from increased investigation and propagation of this African and human heritage and knowledge.

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11. Spirituality in Knowledge Production and the Practice of Traditional Herbal Medicine among the Yoruba People in Southwest Nigeria

Ojo Melvin Agunbiade

Introduction

Traditional medical practice in most cultures is deeply rooted in cultural values, beliefs and practices that have implications on knowledge production and treatment outcomes. Traditional medicine comprises medical knowledge systems that have developed over the years and is defined by the World Health Organization as:

The total of all knowledge, skills and practices informed by the theories, beliefs, and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.

(WHO 2000, 1)

African traditional medical systems were operating long before their contact with Europeans (Sofowora 1982; Twumasi 1975). However, the experience of colonization, political, economic, and socio-cultural factors, coupled with existing epistemological and ontological differences have influenced the gaps between African traditional medical systems and western medicine (Konadu 2007; Oloyede 2010; Ross 2010). Despite this, the global presence of traditional African herbal medicine has increased in recent years as shown by the global market for herbal medicine (Vasisht and Kumar 2004; WHO 2005). At different levels, herbal specialists within the African traditional medical systems are gradually incorporating modern techniques in the packaging and marketing of traditional herbal remedies to increase wider coverage and acceptance (Scott 2010; WHO 2005). To an extent, this picture suggests a responsive system; however, knowledge generation, dissemination and application of traditional herbal medicine in African society have remained culturally defined (Konadu 2007).

Among many African traditional healers, knowledge generation and the transmission and application of herbal medicine in critical health conditions are still carried out in secrecy with spirituality as a form of control (Dime 1995; Omonzejele 2008). The quest for a deeper harmonious interaction between the physical and spiritual dimensions of the human existence may be observed in the everyday practices of the healers in particular (Jegede 2010; Omonzejele 2008; Twumasi 1975). There have been numerous

recent studies on African traditional medical practice (e.g. Jegede 2010; Kayne 2010; Omonzejele 2008), including those that focus on spirituality and supernatural factors in African healing traditions (Konadu 2007, 3–14). However, investigations into the continued relevance of spiritually-infused practices at a local level, the knowledge produced and disseminated by such specialists, and the possible influence of these practices on the outcome of medical treatments, have remained on the periphery. The term ‘spirituality’ has different conceptualisations in the literature (e.g. Olupona 2008, xviii–xix; Zinnbauer and Pargament 2005, 21–22). Within the existing range of definitions, Reed’s (1987) description of spirituality seems more appealing to this study. Reed describes spirituality as a broader concept than religion or religiosity (1987, 336). Indicators of spirituality include prayer, sense of meaning in life, reading and contemplation, sense of closeness to a higher being, interactions with others and other experiences which reflect spiritual interaction or awareness. In Wade Roof’s position, the modern usage of spirituality has changed from an earlier focus on unwavering faith that is built on transcendental powers, to the acknowledgment of the human spirit in the quest for meanings and experiential wholeness (cited in Olupona 2008, xviii).

This study focuses specifically on the Yoruba people whose traditional medicine and herbal medicine in particular consists of two entities: the physical and the spiritual. These aspects are enmeshed in both theory and practice (Jegede 2010). This binary design has inherent epistemological and ontological challenges when validations of therapeutic outcomes are juxtaposed with those of the biomedical system. Evidence for this chapter was based on fieldwork among Yoruba traditional medical practitioners and herb sellers in Southwest, Nigeria. The Yoruba traditional medical system was selected as a microcosm of the African traditional herbal system due to the similarities in the beliefs and philosophical assumptions of Yoruba traditional medicine and a number of other traditional African medical systems (Kayne 2010; Twumasi 1975). Thus, this chapter presents the views of Yoruba herb sellers and traditional medical practitioners on the meaning of ‘spirituality’, and the relevance of spirituality in herbal knowledge acquisition, transmission, and application. It also investigates the perceived relationship between spirituality and the efficacy, or effectiveness, of herbal medicines and therapeutic relations at the interpersonal level.

Using the theory of social practice to analyse the Yoruba cultural worldview, the chapter examines the everyday practices of these medical specialists with emphasis on spiritual activities and assumptions that involve improving their knowledge, healing powers, and social relevance as healers. The chapter starts with an overview of traditional medicine and establishes a cultural basis for the practice of traditional and herbal medicine among the Yoruba people. The second part examines the benefits of using practice theory as a framework for interrogating the everyday activities of social actors within a social field. The third section examines the methodology for this study and the rationale for utilizing a qualitative approach. The conclusions of this chapter present the findings and a context for interrogating the continuing relevance of spirituality in the everyday practices of traditional Yoruba medical practitioners and herb sellers.

Traditional Herbal Medicine within the Yoruba Cultural Worldview

The exact moment when the practice of herbal medicine started in Africa has remained controversial (Lantum 1980; Sofowora 1982). One of the early explanations for the human acquisition of herbal knowledge is the systematic collection of plant materials through careful observation of the environment and harmonious interactions with nature for the treatment of ailments (Lantum 1980). Such interaction does not guarantee an understanding of the plant properties, but it is believed that it enhances practitioners' skilfulness in the use of plants for medicinal purposes (Lantum 1980; Thornton, 2009). Historically, myths have been employed to explain how early humans practiced the art of healing. Among the Yoruba, one dominant myth is the position that herbal medicine started with *Orunmila* who was endowed with knowledge of herbs by *Olodumare* (the Supreme Being). *Orunmila* had a younger brother, *Osanyin*, who gained the knowledge of medicinal herbs by assisting his elder brother to combine drugs. However, the two brothers became separated as *Osanyin* was taken into slavery during inter-tribal wars. *Orunmila* continued the tradition of Herbalism without his brother. After some time, a slave in *Orunmila's* household commented on some medicinal herbs to *Gbinrinbiti* (*Orunmila's* wife), who reported this to her husband. On interacting with the slave, it became clear to *Orunmila* that this slave was his own brother *Osanyin* (Sofowora 1982).

Despite the difficulty in reconciling myth and science, the practice of traditional herbal medicine has largely been influenced by religious and spiritual practices. Plants are still used in the rituals of traditional religion in many parts of Africa (Jegede 2010; Ross 2010; Scott 2010). Some practitioners have described wizards and witches as being invaluable sources of traditional medical knowledge and providers of effective cures, especially for ailments that have defied natural or biomedical explanations and treatment options (Hallen 2000). To a number of African traditional medical specialists, divination as a system is inseparable from knowledge generation as well as care provision (Omonzejele 2008; Ozekhome 1990; Ross 2010). Among the Yoruba people, a predominant system of divination and knowledge creation for health, healing, and other social benefits is the *Ifa* oral tradition.

The *Ifa* (Oracle) oral tradition encompasses a body of knowledge that is indigenous to the Yoruba culture (Abimbola 1975; Jegede 2010). Traditional Yoruba medicine has its roots in the *Ifa* corpus (Jegede 2010). The *Ifa* divination system is made up of two hundred and fifty-six *odus* (verses or stories that make up the *Ifa* literary corpus) that are memorized by the *Ifa* priest. In the Yoruba language, a priest who can be consulted as an oracle is known as *Babalawo* (Jegede 2010). Within the *Ifa* divination system, knowledge production and relevance rests on truth, moral virtues and hard work. In the practice of *Ifa*, divination and revelations are subject to the dynamics of the *odus*, which are built around divinity and human existence. During consultation, the *Babalawo* attains a high level of spirituality, which enhances his ability to draw on deeper information from the world of spirits (Jegede 2010). Thus, practitioners within this system require a high level of perception. As a teacher or apprentice, the continuing or reliable way of working towards discovering relevant knowledge for the advancement of humanity is both an individual and shared responsibility. To achieve this position,

Iwapele (good character) is a prerequisite. As described by Abimbola (1975), *Iwapele* in the Yoruba culture is a normative and religious expression that emphasises building and maintaining healthy social relations as a necessity to attaining success in life. The possession and application of *Iwapele* is a condition that cuts across other spheres of social interactions, including that of healer and patient interaction. Within this holistic framework, the African traditional medical professional is not just a healer, but also a counselor, political figure and a social reformer (Keita, 2007, 34–38).

However, there also exists the possibility of deviating from the virtues of *Iwapele*, since human nature is highly imperfect. To reduce such deviations within the *Ifa* divination system, the practitioner and patient/client interaction is built upon the principle of ‘truth’. In principle, the *Babalawo* recounts and interprets whatever the *Ifa* says during the divination process without distortions. Within this framework, the degree of proficiency in the interpretations of problems is based on the emerged *odus* during the consultation with *Ifa*. While there might be variations from one specialist to the other, in practice, such variations also depend on the practitioners’ knowledge of *Ifa* and adherence to everyday practices that could improve their individual level of spirituality. Thus, as a means of ensuring impartiality and standard practice, traditional medical specialists, patients or clients are expected to reciprocate *Ifa*’s doctrine of truth by adhering to the revelations that emerge during the consultations. As a sacred means of knowledge generation and implementation, *Ifa*’s revelations are often taken as instructions from the ancestors who possess deeper understanding that should be respected for the benefits of those presently living and, indeed, for the coming generations. In the Yoruba culture, social relations are not confined to the living alone. Relations exceed the living, and involve maintaining positive relations with one’s ancestors through normative social relations with others and the continuation of tradition. Against this backdrop, ethics in the Yoruba worldview is conceived as a super-naturalistic reality where ethical issues concern the relationship between spiritual beings and humans. Indeed, it also imbues the relationship amongst spiritual beings with sacredness (Bewaji 2005).

African traditional medical practitioners put much emphasis on supernatural forces in their explanations for care provision and knowledge generation and utilisation (Konadu 2007; Makinde 1985; Omonzejele 2008). However, with the exception of Jegede (2010), studies that have previously examined the traditional Yoruba medical system have neglected to consider the continued relevance of spirituality in the everyday practices of traditional medical practitioners (Odebiyi 1990; Osemeobo 1993; Oyebola 1980). In Dime’s opinion, ‘the whole myriad of things which constitute the universe are mystically one and constitute only one thing, one reality; everything is a part of the other that makes up reality, the entire cosmos or universe’ (Dime 1995, 28). Thus, exploring the process of knowledge production as contained in the everyday practices of traditional medical practitioners can open up additional debates regarding other aspects of society.

Theoretical Framework

Practice theory as a body of knowledge has its intellectual roots in the works of individuals such as Garfinkel, Bourdieu, Giddens and Foucault (Ritzer 2008, 233). The

theory represents a diverse array of different but related ideas or theories espousing the affinity and continuum of influence that exist in the interactions of social actors with, and within, a cultural context, and how their active participation affects their social realities (Postill 2010; Ritzer 2008, 526). Theorists within this framework attempt to articulate the ways in which identity and individual agency rely on and build cultural forms. As a valuable theoretical tool, social practice theory provides a framework for understanding and analyzing the roles of everyday practices on human conduct and the construction of realities (Ritzer 2008, 526–27). However, much of the literature concerned with social practice theory has been criticized for its high philosophical dispositions and distance from empirical verification (Warde 2005). As a body of knowledge, the theory tends towards idealization, abstractness, and insufficient attention to the social processes involved in the production and propagation of practices (Reckwitz 2002; Warde 2005). Despite such criticisms, social practice theory provides a constructive framework through which to explore and understand everyday practices (Ritzer 2008, 527; Postill 2010).

Following Postill (2010), the term ‘practice’ is defined in this study as the culmination of everyday, ordinary acts that are engaged in either consciously or unconsciously, and which are relevant to the day-to-day lives of traditional medical practitioners, including their understanding of self, herbs, patients/clients, and other realities in their cultural context. However, practices are social phenomena, in the sense that, firstly, participating in them entails immersion in an extensive network of coexistence that embraces varying sets of people. Secondly, their organization is part of the ‘nexuses of doings and sayings that comprise them’ (Schatzki 2001, 87). As social phenomena, practices are traceable to the network of interactions social actors engage in regularly. Practices are not *sui generis* of human actions; rather they are created, recreated and interpreted within social relations (Giddens 1984, 2). Building on Bourdieu and Giddens, Schatzki argued that ‘the social is a field of embodied and materially interwoven practices centrally organized around shared practical understandings’ (Schatzki 2001, 3). The continuation of practices over time depends on ‘the successful inculcation of shared embodied competence’ (Schatzki 2001, 3) as well as on their continued performance (Schatzki 1996). Because activities (or actions) and bodies ‘are constituted’ within practices, ‘the skilled body’ is where activity and mind as well as individual and society meet (Schatzki 2001, 3).

Practices that exist within social fields are dynamic and change within space and time. As social actors, traditional medical practitioners operate in a continuum of social interactions within structures and amongst other actors. Within these interactions, repression, imitation, innovation and regeneration of beliefs and ideas that could call for replacement or modifications in the existing practices are liable to occur. Thus, both the ‘internal’ skilled person and external environment of the practitioners constitute analytical frameworks at which deeper understanding of present practices can be explored in-depth (Randles and Warde 2006, 229). Whilst the internal, different practices are somewhat controllable, the external environment, which consists of technology, political spheres, and economic factors, is largely uncontrollable. While this does not constitute a passive position, or the noninvolvement of practitioners in influencing their external environments, it only reiterates the lack of *complete* control.

Methodology

This ongoing study involved an in-depth interrogation of spirituality in the everyday practices of traditional medical practitioners and herb sellers. The data collection took place in four locations: Ile-Ife and Ilesa, in Osun State and Oyingbo, and Mushin, in Lagos state. Both states are part of the five predominant Yoruba states in southwest Nigeria. Traditional medical practitioners, including herb sellers, provide essential, primary care services for rural and urban dwellers in Nigeria (FMOH 1988). There are different categories of traditional medical providers in Nigeria, including those found among the Yoruba people (Adekson 2003; Oyebola 1980). Two categories of participants – namely, herb sellers and traditional medical practitioners – were recruited from these four locations. The herb sellers were selected from Oyingbo and Mushin markets, located in the suburb areas of Lagos State. The traditional medical practitioners were recruited from Ile-Ife and Ilesa, two ancient and historical towns in Osun State, southwest Nigeria. The selection of the participants was determined by economic and social factors that influenced the prevalence of certain practitioners in certain places. Herb selling is better established in urban areas in Nigeria than in the rural locations where the materials are sourced. In contrast, more traditional medical practitioners are found in rural areas than in urban areas.

Relevant data was collected through face-to-face in-depth interviews with thirty-five herb sellers and twenty traditional medical practitioners. All the interviews were tape recorded with the consent of the participants. The interviews were conducted in the Yoruba language at locations preferred by the participants. With the assistance of two experts in both languages, the interviews were transcribed verbatim before translating it to English. A qualitative content analysis that entailed coding responses, creating categories, and identifying recurring themes from the participants' expressions was used in analyzing the data (see Miles and Huberman 1994; Tesch 1990, 91).

Participant Profiles

Of the traditional medical practitioner informants, eighteen were male while only two of them were female. The average age of the traditional medical practitioners was 58.5 years. In contrast, there were more females (27) than males (8) among the herb sellers. This latter trend may be a result of the social perpetuation of the stereotypical view that trading in herbs should be a feminine occupation (Agunbiade, Opatola and Titilayo 2012). Similarly, traditional medical occupations like the *Ifa* Priest/*Babalawo* (diviners) are predominantly considered male occupations. The average age of the male herb sellers was 52 years while that of the females was 58 years. A large proportion of all the informants had a low level of formal education. Polygamy was practiced by two thirds of all the informants (36). It was not a surprise that some of the traditional medical practitioners also described themselves as either Christians or Muslims. Religious diversity has already been reported among community members and traditional medical practitioners in Nigeria (Westerlund 2006, 124; Jegede 2002).

Findings and Discussions

Ori (inner head), dexterity and occupational choice

The *ori* ('inner head' or spiritual intuition) and dexterity (aptitude) were essential to the informants' narratives on occupational choice as well as an individual's level of skilfulness in prescribing potent medicines or herbs. Both the inner head and dexterity in the Yoruba worldview are in the realm of divine determinism. Some individuals within this framework are, by virtue of their *ori*, destined to excel and find fulfilment in certain occupations, especially when exposed to the right training and skills (Olurode 2007). The belief of the Yoruba people is that certain life events, including achievements in all spheres of life, are relatively determined (Abimbola 1975). This position does not imply absolute determinism, but rather emphasises the indispensable interest of a supreme being in all human affairs and the need to constantly harness available energy and resources towards practices that will result in the fulfilment of the divine agenda (Balogun 2007). In Iroegbu's words, '[c]ausality is not a mere conceptual reality. It is an existential fact that what is, and whatever force we see, is intricately involved in other forces: in origin, action, perfection and end' (Iroegbu 1995, 287).

I spent 15 futile years of my productive life in search of what occupation I was destined for. I started as a police officer; delved into teaching before becoming a *Babalawo*. In my own case, it was by birth that my mother was told that I will be an *Ifa* priest, but I refused until things started going wrong for me.

(Male traditional medical practitioner aged 69)

Some of the informants had early recognition of their calling from their young adulthood. Praise from those around them concerning their level of dexterity provided clues as to their calling. Divination and prayers were made before a final decision was reached. It is noteworthy that such decisions were not without their challenges. Six other informants who were herb sellers gave accounts of both success and failures in other spheres of life. Their arguments were that whilst *ori* determines an individual's career and life fulfillment as a whole, other factors are required to overcome life challenges in one's career and other areas. At such difficult periods, courage, patience and prayers are considered essential for providing a solution.

Through the narratives recorded in this study, the role of divinity was evident as the participants recounted both pleasant and unpleasant situational experiences as antecedents to their current involvement in traditional medicine. The practitioners described medicine as a sacred calling that must be done by those with such *ori* and *ayanmo* (destiny). In Olurode's (2007) view, the Yoruba belief system portrays destiny as a necessity to success in any chosen career. The consensus among the study participants was that with the right choice of a career, dexterity in practice comes easily when combined with spiritual activities such as sacrifices, rituals, prayers, on-the-job-training, sharing and acquiring new knowledge with and through peers.

Holistic Conception of Knowledge

Knowledge, also known as *imo*, is described as a multidimensional reality. While certain types of knowledge did not emerge from the data, a dominant form that did become apparent was the knowledge of the interrelationship between human existence and nature. Dime has also noted that the 'existence of structural kinship between man and nature; man and the spirit world are prominent in the African view of reality' (Dime 1995, 28). Within this framework, the participants described their knowledge of medicine and herbs as a continuum of interconnectivity of all forms of realities. However, the ability to understand the nature of events, objects, social relations, and the linkages between physical and spiritual existence of humans differs from one person to another. Spiritualist and traditional medical practitioners are believed to possess a greater understanding of such knowledge and, along with witches and sorcerers, can use it to a competitive advantage:

The ability to use and control in the supernatural is widely believed among the Yoruba people as they possess relevant knowledge on primordial secret names of the spiritual agents. In most cases, sorcerers and witches know the secret names and use them to do evil.

(Dopamu 2000, 27)

In the informants' view, the acquisition of this form of knowledge is continuous and could range from partial to a deeper (but not perfect) level of understanding. The absence of a thorough grasp of life events is said to derive from human frailty and disobedience. And yet, the informants argued in support of openness to suggestions from both explainable and non-explainable sources as a precondition for attaining deeper knowledge. Discipline and openness of the mind at this point does not happen on its own violation. Oyebola (1981) has argued that the ethics of traditional medicine emphasise truthfulness, discipline, and continual efforts to better understand the continuum between the physical and the spiritual. With the simultaneous incorporation of some medical practices from Islam or Christianity alongside traditional religion, four of the traditional medical healers interviewed for this study argued that sustained and fervent prayers, fasting, and meditation can expose a devoted practitioner to the knowledge of the spiritual forces that govern the universe for humanity. The traditional healers also described how this helped them in assisting a number of clients with problems defined as 'spiritual'. From an informants' narrative:

Knowing requires conscious efforts and discipline. A number of us [traditional medical practitioners] 'after being called' had to sacrifice so much in material and nonmaterial before we got to this present of knowledge. Even now, learning continues since no one knows it all.

(Male traditional medical practitioner, aged 67)

Spirituality in Everyday Practices

It seems, therefore, that an unending desire to acquire a deeper understanding of traditional medicine and herbs was paramount to all the participants. However, Lambo

once described this process as shrouded with 'unnecessary' practices, actions that were conducted to mystify the actual nature of the practitioners' magic or scientific discovery. Thus, decoding this process requires both a deeper understanding of African metaphysics and the cooperation of renowned practitioners within this medical system (Lambo 1979). The cooperation of renowned practitioners has substantial benefits, especially with the reliance on oral approaches to tutelage and apprenticeship in this medical system. Over-reliance on oral tutelage without adequate documentation on the part of the teacher and the learner has implications on sustaining standardised practices within this medical system. While a couple of traditional healers have cultivated the practice of proper documentation of their healing knowledge and practices, the absence of formal education system tailored towards generating and transferring traditional medical knowledge in part or whole has consequences for the system and the society. However, the prevailing cooperation and the quality of tutelage can be strengthened if the traditional medical association in Nigeria and other African countries emphasise professionalism and the strict adherence of practitioners to the basic philosophy of fulfilling community needs before personal gratification. The satisfaction associated with providing solutions to human problems has been described as the hallmark of wholesome, traditional medicine (Oyebola 1981). From a participant:

A true traditional medical practitioner should seek more knowledge and power that would enhance patients' or clients' well-being. More rewards greater than money are bound to come your ways, by satisfying a client or patient.

(Female Herb seller, aged 52)

As Omonzejele (2008) comments, medicine among Africans is hinged on sound morals and virtues which separate exemplary practice from that driven by profit or material accumulation. An important means of adhering to such standards may be found in the emphasis on divination. The practice of divination is perceived as essential to making informed decisions and providing desirable help when needed.

Divination and Revelations

Knowledge generation and verification of treatment outcomes in any medical system is inseparable from philosophical positions regarding medicine. In much of African traditional medicine, divination has remained an integral part of practice and the mode of knowledge acquisition.

It is the principal way of revealing the causes of disease and ill health. The items used for divination include, among others native white chalk, native gin, native kola nut, and alligator pepper. These items are highly symbolic as they constitute different and relevant means of achieving desired results.

(Omonzejele 2008, 122)

Largely, the means or mediums to divination differ according to the practitioners' internal and external environments; indeed, studies have confirmed the influence of environmental factors on the practitioner's information-seeking behaviour. The environment of the African traditional medical practitioner is shrouded in secrecy,

and this reflects their level of reliance on informal sources of information (Olatokun and Ajagbe 2010).

Divination is like a travel guide to a visitor. We are all visitors on this earth, and without divination we will lose our bearing and purpose of coming since there is no one that will not 'go back' [die].

(Herb seller, aged 53)

The particularity of divination and revelation also makes standardization problematic as individuals differ in adhering to the procedures and process of knowledge generation and utilization. Despite this, practitioners are initiated into the practice of divination and the superiority of revelations as an informed process of knowledge acquisition for effective care delivery. Ozekhome argued that divination brings about revelations: 'revealing the unknown and at times cloudy future, unmasking the abysmal tunnel of the dark, nebulous past, and analyzing the vibrant but malleable present' (Ozekhome 1990, 64). In both theory and practice, revelations are seen as an offshoot of divination: 'Revelations take the decoding of messages from the spiritual abode encased in the literature of tablets issuing from the esoteric whispers of the present spiritual agencies' (Ozekhome 1990, 64).

Incantations and Harmony with Nature

The unending existence of physical, mental, and social problems in human society calls for constant search for solutions, one of which, according to the informants, could be found in the power of the spoken word. As in many other African worldviews, the spoken word occupies a central position in the Yoruba construction of realities. *Oro* (the spoken word) is perceived as fundamental to all creation. It can be used for evil or noble ends; awakening the healing powers in plants as well as enhancing the healing process in a health condition. The existence of harmonious interactions between the traditional medical practitioners and nature was widely emphasized, especially in the use of medicinal plants. This is necessary for appropriating the healing powers in plants as well for increasing the practitioners' body of knowledge. With the right knowledge, spoken words could be used as an incantation, as suggested by one of the informants: 'Some plants would lose their potency except you gather them using the right incantation' (Herb seller, aged 58). The knowledge of what, when and how to use incantations (*ofo/ogede/igede*) is widely circulated among those who have been properly initiated into the traditional medical system. Not all humans who have knowledge of what, when and how to use the spoken word can boast of achieving the desired results. Among the informants in this study, a common position was that such knowledge must be backed with *ase* (power of affirmation). Without *ase*, the participants argued that an individual may know how to chant incantations, but this will not achieve the desired outcome, especially when the individual doing the chanting has not been properly inducted into the profession. Improper and wrong use of incantations could cause mishaps. At such points, an unexpected evil outcome may befall the chanter since the forces within the atmosphere could have been wrongly invoked (Jegade, 2010).

In traditional Yoruba medicine, incantations can be used to ward off evil forces and engage in communication with the plant. Evil forces are found everywhere. Since most of the herbal plants are gathered from the forest, there is the need to ward off these spirits since they can destroy the efficacy of a plant. Thus, possession of the power of the spoken word and the right incantation that can invoke the innate potent force and life in plants.

(Traditional medical practitioner, aged 69)

Constant and conscious recitation of *ofo* (incantation) enhances a practitioner's ability and expertise in recording desired successes or outcomes. It is through rigorous learning and practices that knowledge and skills improve. Indeed, 'satisfaction' with immediate performance and results as a traditional healer can cut off the individual from the realm of power. Additional efforts, including mediation, the memorization of successful procedures, and sacrifices, are further ways to increase the practitioners' knowledge-base.

Meditation and Prayers

Meditation and praying as spiritual practices featured prominently in the testimony of the informants. From their perspective, meditation through deep reflection provides an opportunity to understand all forms of realities, including human existence.

Meditation allows you to assimilate what is coming from the spiritual and physical worlds. Growth at any level comes by assimilating what comes outside.

(Traditional medical practitioner, aged 63)

As a Muslim and a traditional medical practitioner, meditation and constant prayers are virtues that are central to Islam. It is easier negotiating many difficulties in the spiritual realm through meditation and prayers. After this, sacrifice would then commence depending on the nature of the problem.

(Male traditional medical practitioner aged 72)

Meditation occupies a focal position in achieving excellence and fulfilment in practice for both old and new entrants. To the practitioners that have been working for a number of decades, meditation and constant prayers to the gods have been repeatedly successful for both them and their clients. Most practitioners and herb sellers expressed the strong value of prayer. Before sacrifices can be accepted, for example, one needs to combine it with prayers:

Only prayers can change things and not 'powers'. It is when you pray with ase [power of the spoken word] that you enjoy the benefit most. At that level, the providential forces are activated to help you in all your doings.

(Female traditional medical practitioner, aged 58)

When we sell herbs to our customers, we also back it with prayers that whatever purpose the herbs are used for will yield positive results and our customers and clients appreciate this so much.

(Female herb seller, aged 60)

I combine traditional religion and practices with my faith. The results have been exceptional for me.

(Male traditional medical practitioner, aged 62).

Sacrifices and Rituals

The everyday practices of an average traditional medical practitioner require constant sacrifice and rituals in one form or the other. The final aim of any divination process and the associated revelations is to understand the causal links around a reality and the plausible measures that could produce an expected outcome. Sacrifices and rituals represent the means of arriving at this end. One of the informants described sacrifice as:

[A]n appeasement. Etutu [sacrifice in Yoruba language] is a way of asking for forgiveness or a plea for a way out of darkness or confusion. All humans and societies engage in different sacrifices at one level or form. It all depends on the medium and the context, but all I know is that without sacrifice there cannot be progress. I am aware that both Christianity and Islam support sacrifice in one way or the other.

(Male traditional medical practitioner, aged 61)

The moment you engage in one sacrifice or the other, then rituals must follow. Appropriate rituals must guide proper divination, revelations and acceptance of sacrifice.

(Male traditional medical practitioner, aged 66)

Like the divergence that occurs in divination practices, sacrifices and rituals also differ based on the practitioner's environment and status. At the level of initiation of a new entrant, certain sacrifices and rituals may be recommended to ensure a successful outcome. It is intriguing to note that this form of consecration also extends into other modes of practice. Experienced traditional healers and new entrants engage in activities that are considered 'sacred' in anticipation of future healing powers or spiritual inspirations. Common among such activities are fetish dancing, singing, spiritual possession and meditation as, for example, found among traditional medical specialists in Ghana (Twumasi 1975). According to Idowu (1973, 201), rituals constitute the way of consecrating African traditional medicine, as medicine without consecration for Africans is meaningless. To an extent, sacrifices and rituals have remained essential in the care-seeking process of an average African, especially in the event of a serious health condition (Omonzejele 2008). Studies have shown the existence of plural health-seeking practices, as patients believe in the need for consecration by way of sacrifice or rituals to enhance the potency of medical treatments that would otherwise fail when applied without this form of sanctification (Omonzejele 2008; Jegede 2002). Functionally, Ozekhome (1990) further argued that sacrifices and rituals dedicated to the gods and the ancestors enhance the clarity of divination and acts to improve the efficacy of whatever treatments the medicine man/woman prescribes for the patient's medical condition.

Conclusion

The findings discussed show that the traditional medical system places a high premium on 'spirituality' as depicted in the everyday practices of the traditional medical practitioners. This focus on spirituality is strongly embedded in the cultural values, beliefs and practices of the Yoruba people. These factors have remained dominant into the present day and may account for the existing variations in knowledge production and transmission in African traditional medical systems. The theory of social practice guided the findings presented in this chapter. The framework provided an avenue through which to understand and investigate how practitioners within the Yoruba traditional medical system shape, and are shaped by, the cultural atmosphere in which they live. While this tradition of medical practice has epistemological and ontological issues that are challenged when validation is attempted through the apparatus of biomedicine, this traditional medical system is not a closed one. Slowly, practitioners within this system are incorporating practices and ideas from other medical and healing systems in improving their own practice.

Despite the benefits of acting within the global market, practitioners within the Yoruba traditional medical system have held tenaciously to the cultural system from which their healing repertoires emerged. However, this does not represent a strict or unchanging medical system. The adoption of some meditation practices among Christian and Islamic faith healers confirm that practices that yield both spiritual and physical benefits have been incorporated into the medical systems. While a level of variation may exist at individual and group levels, the adoption and utilization of such practices as narrated by some of the informants indicate an influx of ideologies from other sub-systems within the larger social or global system. Largely, openness of practitioners to ideas and practices found outside their culture indicate favourable disposition to integrate practices that could further enhance the social relevance of the practitioners as well as the acceptability of their therapeutic regimes among diverse social categories. Careful interrogation of relevant practices outside the Yoruba culture by the traditional medical practitioners has some benefits. It could result in innovations and the possible emergence of more effective therapeutic regimes. Such actions may be beneficial in addressing the increasing disease burden and health challenges in Nigeria and the African continent. The ontological and epistemological differences notwithstanding, specialists in the biomedical system can subject the existing body of African traditional herbal medicine to further therapeutic advances, especially in the area of drug production. Success stories have been recorded in South Africa (Taylor *et al.* 2001), and other African countries can emulate this either at the macro- or micro-level.

The reliance on spirituality in knowledge production also has implications on the client/patient as well as the practitioner or specialists within this traditional medical system. With regards to the client/patient, right promotion and protection as well as quality assurance in asymmetrical power relations that govern therapeutic encounters becomes challenging. For example, traditional medicine is highly receptive to accommodate medically unexplainable conditions. With the increasing prevalence and diversity in nature and symptoms of such conditions and their non-amenability

to biomedical explanations, the existence of alternative forms of explanations may be promising (Mik-Meyer and Obling, 2012). However, like the challenges being confronted by biomedical practitioners and patients treated under such conditions, practitioners within the traditional medical system may also be facing similar or more challenges which have not been accounted for.

While the validity of knowledge from transcendental sources goes beyond empirical verification, the outcome or utility of such knowledge may provide an option for confirmation by outsiders. With the presence of charlatans in any healing or medical system, strict regulations and monitoring of practitioners' activities may be useful in minimizing exploitations of other clients/patients within the traditional medical system. Furthermore, adherence to standard practices that are aimed at promoting community or societal wellbeing over the practitioners' personal benefits could be challenging for new entrants into the system. There are new practices already established among the informants in this study whose roots are traceable to religions foreign to the Yoruba people. Hence, with the effects of globalisation and continuous interactions of practitioners with other healing or medical system, newer routines of practice are expected to emerge.

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